Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN8201	A. BUILDING _____ B. WING _____	03/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRISTOL NURSING HOME	261 NORTH STREET BRISTOL, TN 37625

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments During the annual Licensure Survey conducted on March 26-31, 2012, the facility was cited a Type "A" penalty for failure to ensure policies and procedures were in place to provide supervision to protect forty-two residents on the second floor from physical and mental abuse. The facility's failure placed all the residents on the second floor in an environment which was detrimental to their health, safety, and welfare. Complaint investigation #29451 was completed during the annual Licensure Survey. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 000	**This plan constitutes our credible allegation of compliance. However, the submission of this allegation of compliance is not an admission that a deficiency exists or that one was cited correctly. This allegation of compliance is submitted to meet the requirements established by state and federal law. This allegation of compliance is provided to reduce the scope and Severity of the F-tags cited as an Immediate Jeopardy**	
N 400	1200-8-6-.04 Administration This Rule is not met as evidenced by: Based on interview the facility failed to apply for a waiver from the State to allow the facility's administrator to act as an administrator in the State of Virginia and State of Tennessee. The findings included: Interview on March 26, 2012, at 2:00p.m., with the Administrator, in the Administrator's Office, revealed the facility was located in the State of Tennessee and Virginia. Continued interview, at that time, confirmed the facility's Administrator was the Administrator for both the Tennessee and the Virginia side of the facility.	N 400	A waiver request has been submitted from the board for licensing healthcare facilities and the determination of need will be made by the board.	
N 401	1200-8-6-.04(1) Administration (1) The nursing home shall have a full-time (working at least 32 hours per week)	N 401		4/16/12

Christoph A. Gaddy
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Administrator

(X6) DATE: 4/16/12

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N 401	Continued From page 1 administrator licensed in Tennessee, who shall not function as the director of nursing. Any change of administrators shall be reported in writing to the department within fifteen (15) days. The administrator shall designate in writing an individual to act in his/her absence in order to provide the nursing home with administrative direction at all times. The administrator shall assure the provision of appropriate fiscal resources and personnel required to meet the needs of the residents. This Rule is not met as evidenced by: Based on medical record review, observation, review of facility documentation, interview, and review of facility policy, the facility failed to be administered in a manner to ensure effective systems were in place to identify and investigate incidents of alleged abuse perpetrated by one resident (#21) with three residents (#17, #32, and #36); to formulate and implement a behavior care plan for two residents (#21 and #35) with physically aggressive behaviors; and to provide adequate staff for supervision of aggressive behaviors for two residents (#21 and #35) with behavioral problems. The facility's failure placed all the residents on the 2nd Tennessee (2nd TN) unit in an environment which was detrimental to their health, safety, and welfare. The findings included: Interview with LPN #6, on March 30, 2012, at 9:25 a.m., and 10:00 a.m., at the 2nd TN nursing	N 401	• **On 3/30/2012 members of the quality assurance committee, Director of Nursing, Assistant Director of Nursing and or the Chief Executive, Corporate Director of clinical services reviewed the Staffing levels on 2nd Tennessee and decided to increase staffing by 43% (4- staff members resulting in a 1C.N.A to 7 residents) on the 7A-7P shift and increased by 25% (2 staff members resulting in 1 C.N.A. to 8 residents) on the 7P -7A shift. Staffing will** be increased to six nursing **assistants on the 7A-7P shift and five nursing assistants on the 7P – 7A shift as soon as the facility can maintain the new staffing level. This staffing will be permanent.** Date of Compliance April 11, 2012	

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N 401	Continued From page 2 station, confirmed resident #21 had a history of aggressive behaviors. Continued interview confirmed the resident was difficult to redirect. Continued interview confirmed there were times resident #21 needed to be on one to one supervision or every 15 minute checks, for the safety of other residents, but the unit did not always have available staff to monitor the resident more frequently than every 30 minutes. Interviews with the Social Services Director and the Senior Director of Clinical Services on March 30, 2012, at 10:45 a.m., in the Assistant Director of Nursing (ADON's) office, confirmed the facility was aware of resident #21's aggressive behaviors and having hit other residents including resident #35. Further interview confirmed every thirty minute monitoring had been provided, but the resident was capable of hurting other residents in a thirty minute time frame. Interviews with the Senior Director of Clinical Services on March 30, 2012, at 12:20 p.m., in the conference room and with the DON on March 31, 2012, at 9:30 a.m., in the ADON's office, confirmed the facility had no incident reports, investigations or interventions related to the witnessed incidents regarding residents #21, #17, #32, #35, and #36 and no incidents had been investigated as possible abuse. Further interviews confirmed they were unaware of the incidents. Refer to 1200-8-6-.04(15) (N-424) Administration	N 401	• **Resident # 21 was placed on fifteen minute observation on 3/30/2012 at 10:30 am until he was transferred to another facility.** • **Resident #21 was transferred to the Medical Center for an Evaluation and placement to a behavior unit on 3/30/2012 at 4:00pm.** • **The social worker completed a PHQ9 assessment Res. # 17 on 3/31/2012 to assess this resident for signs and symptoms of depression and to identify possible changes in signs and symptoms of mood distress since her last assessment. The assessment revealed that there was no change from the residents' baseline.** • **(The PHQ-9 is a 9 item patient health questionnaire. A validated interview that screens for symptoms of depression. It provides a standardized severity score and a rating for evidence of a depressive disorder. The total severity provides a standard of communication with clinicians and mental health specialist.)**	
N 424	1200-8-6-.04(15) Administration (15)Each nursing home shall adopt safety policies for the protection of residents from accident and injury.	N 424		

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N 424	1200-8-6-.04(15) Administration (15)Each nursing home shall adopt safety policies for the protection of residents from accident and injury.	N 424		

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N 401	Continued From page 2 station, confirmed resident #21 had a history of aggressive behaviors. Continued interview confirmed the resident was difficult to redirect. Continued interview confirmed there were times resident #21 needed to be on one to one supervision or every 15 minute checks, for the safety of other residents, but the unit did not always have available staff to monitor the resident more frequently than every 30 minutes. Interviews with the Social Services Director and the Senior Director of Clinical Services on March 30, 2012, at 10:45 a.m., in the Assistant Director of Nursing (ADON's) office, confirmed the facility was aware of resident #21's aggressive behaviors and having hit other residents including resident #35. Further interview confirmed every thirty minute monitoring had been provided, but the resident was capable of hurting other residents in a thirty minute time frame. Interviews with the Senior Director of Clinical Services on March 30, 2012, at 12:20 p.m., in the conference room and with the DON on March 31, 2012, at 9:30 a.m., in the ADON's office, confirmed the facility had no incident reports, investigations or interventions related to the witnessed incidents regarding residents #21, #17, #32, #35, and #36 and no incidents had been investigated as possible abuse. Further interviews confirmed they were unaware of the incidents. Refer to 1200-8-6-.04(15) (N-424) Administration	N 401	• **The RN supervisor completed an audit on all blood sugar flow sheets to assess for compliance with M.D. notification related to hypo/hyperglycemic on 4/10/2012.** **The DON, ADON and Social Services reviewed psychiatric services progress notes for visit from 3/30/2012 to 4/3/2012 to ensure psychiatric recommendations were completed timely. All recommendations were place in the physician notification folder for the physician to review.** • **MD and or NP make facility visits four times a week to assess the residents and to review consultant recommendations that have been placed in the physician folder.** **Skin assessment was completed on 100% of the resident in 2nd Tennessee by the charge nurse to assess for unknown bruises and or abrasions.**	Date of Completion 4/1/12
N 424	1200-8-6-.04(15) Administration (15)Each nursing home shall adopt safety policies for the protection of residents from accident and injury.	N 424		

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	TN8201	A. BUILDING _____ B. WING _____	03/31/2012

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N 424	1200-8-6-.04(15) Administration (15)Each nursing home shall adopt safety policies for the protection of residents from accident and injury.	N 424		

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N 424	1200-8-6-.04(15) Administration (15)Each nursing home shall adopt safety policies for the protection of residents from accident and injury.	N 424		

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N 424	Continued From page 3 This Rule is not met as evidenced by: Based on medical record review, observation, interview, and review of facility documentation, the facility failed to provide supervision for aggressive behaviors for two residents (#21 and #35) with behavioral problems; failed to ensure safe bed rails for one resident (#8); and failed to ensure supervision for wandering for one resident (#17) of thirty-nine residents reviewed. The facility's failure to supervise resident #21 and resident #35 with aggressive and abusive behaviors placed the residents on the 2nd Tennessee (2nd TN) unit in an environment which was detrimental to their health, safety, and welfare. The findings included: Resident #21 was admitted to the facility on August 19, 2011, with diagnoses including Mental Disorder, Anxiety, and Previous Head Injury - Traumatic. Medical record review of an assessment dated February 12, 2012, revealed the resident scored 4 out of 15 on the Brief Interview for Mental Status, indicating severe cognitive impairment, had physical behavioral symptoms directed toward others, and was independent with ambulation. Medical record review of the Care Plan last reviewed February 16, 2012, revealed the only behavior and cognitive problems the facility had identified and implemented interventions for were related to "...impaired thought processes, short	N 424	**The facility will ensure that the residents' environment is as free of accidents hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.** ***1. What corrective actions(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?*** **• On March 27, 2012 the full side rails were immediately removed from Resident # 8 bed. The resident was placed in a Geri-chair. The residents' old bed was replaced with a new bed with assist rails within one hour.** **• A side rail assessment and the care plan were updated on 4/9/2012 for resident # 8 by the unit manager. The unit manager notified the staff of the updated care plan immediately.**	Completion Date 4/11/12

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N 424	Continued From page 4 and long term memory loss associated with dementia...Potential for social isolation related to facility admission and cognitive impairment...Experiences periods of high anxiety AEB (as exemplified by) cursing, pacing, and combative behavior toward staff/ex wife related to dementia, newly admitted..." Review of the care plan revealed interventions included, " ...Approach resident warmly and positively...Allow resident opportunity to make choices and participate in cares. Reinforce with resident unacceptability of resident's verbal abuse. Do not argue with resident. Remove resident from public area when behavior is disruptive. Talk with resident in calm voice when behavior is disruptive. Social Services to evaluate resident and visit with resident prn (as needed). Monitor and document resident behavior. Report increase in negative behavior to physician ..." Medical record review of the Nurse's Notes dated December 4, 2011, at 8:30 p.m., revealed, "Res (resident) had altercation (with) another res. Res caught rummaging in res room. Both separated. Res redirected..." Medical record review of the Mental/Behavioral Health Progress Notes dated January 3, 2012, revealed, "...frustrated/angry...delusional beliefs...replied that he was concerned about his ex-wife...went on to say that he has seen his wife w/ (with) other residents and this bothered him...went on to reiterate further delusional beliefs about his ex-wife's behaviors...tends to obsess about this..." Medical record review of the Nurse's Notes dated January 12, 2012, at 6:30 p.m., revealed, "...Resident wandering (up and down) hallway pushing residents in rooms pushing chairs	N 424	• **The care plan for res. # 17 was updated by social services, MDS Coordinator and Quality Assurance Nurse and Sr. Director of clinical services on 03/31/2012 to reflect the need to notify the MD and social services of changes in mood and behaviors.** • **On 4/11/2012 the care plan for res. # 17 was updated to include: redirect the resident with activity diversion when wandering such as folding wash cloths, looking at the sand hour glass and magazines.** • **The Director of Nursing updated the care guide for resident #17 on 4/11/2012with the diversional activities such as folding wash cloths, looking at the sand hour glass and magazines.** o • **The charge nurses will utilize the Psychoactive Medication monthly flow record to document resident changes in mood and or behaviors. It is the responsibility of the charge nurses to notify the MD and social services of any mood and behavior changes.** • **The charge nurse will notify the MD and social services of residents exhibiting abusive behaviors immediately.**	Completion Date 4/11/12

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N 424	Continued From page 5 around hallways - at nsg (nursing) station frequent (with) request re: (regarding) room stay. Resident also displaying some protectiveness i.e. (that is) female residents - resident raised his voice in loud tone this am (morning) when talking to male resident. This resident thought other male resident was (after) his wife. Residents separated - explained to this resident (reoriented) minimal success noted..." Medical record review revealed no new interventions were implemented for increased supervision of resident #21. Interview with Certified Nurse Aide (CNA) #1 on March 30, 2012, at 1:52 p.m., in the conference room, confirmed resident #21 had aggressive behaviors towards other male residents and had been known to strike residents. Continued interview confirmed the resident frequently wandered the halls of the units, in other resident rooms, and liked to be with female residents in their rooms. Continued interview confirmed the CNA had worked on two occasions in January 2012, when the resident was seen exiting a female resident's room. Continued interview confirmed the first instance the CNA recalled was around the week of January 9, 2012, the resident was seen exiting a room (empty resident room which had not been assigned to any residents) carrying linen. Interview confirmed the CNA entered the room and resident #32 was in bed with no clothes on, and a brief had been removed and was laying on the bed with blood present in the brief. Continued interview confirmed the CNA reported the incident to LPN #11. Continued interview confirmed the CNA also observed the resident (resident #21) exiting female resident #17's room sometime in January, and upon entering the room, found the resident fully	N 424	• **The social worker completed a PHQ9 assessment on 3/31/2012 to assess resident #17 for signs and symptoms of depression and to identify possible changes in signs and symptoms of mood distress since her last assessment. The assessment revealed that there was no change from the residents' baseline.** • **(The PHQ-9 is a 9 item patient health questionnaire. A validated interview that screens for symptoms of depression. It provides a standardized severity score and a rating for evidence of a depressive disorder. The total severity provides a standard of communication with clinicians and mental health specialist.)** • **The charge completed a Skin assessments on resident # 17 on 3/18/2012, 3/22/2012 and 3/26/2012 all indicate no new skin issues.** • **Resident # 21 was placed on fifteen minute observation on 3/30/2012 at 10:30 am.** • **Resident #21 was transferred to the Medical Center for an Evaluation and placement to a behavior unit on 3/30/2012 at 4:00pm. This resident will not be readmitted to the facility.**	Completion Date 4/11/12

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N 424	Continued From page 6 clothed, one side of the brief undone, and pants on the resident. Continued interview confirmed staff "just redirected" the resident when he was noted on the female hall. Interview with Licensed Practical Nurse (LPN) #11 on March 31, 2012, at 7:15 a.m., and 9:00 a.m., on 2nd Tennessee, confirmed the resident #21 was a "handful" and nursing were "constantly trying to keep track of where he might be...takes clothes." Continued interview confirmed the LPN was working sometime in January when CNA #1 reported to LPN #11 resident # 21 had exited a room (empty resident room which had not been assigned to any residents) carrying ladies clothing. Continued interview confirmed resident #32 was in the room with no clothes on, and a brief had been removed (unknown who removed) with blood in the brief and blood on the resident's rectal area. Continued interview confirmed LPN #11 was not the nurse assigned to care for resident #32 but cleaned the resident and reported it to the resident's nurse. Continued interview confirmed the resident was sent to the hospital the same day. Continued interview confirmed the LPN did not remember what date it was, but the resident was sent to the hospital and the occurrence was around 11:00 a.m., to 12:00 p.m. Continued interview confirmed the LPN had never known resident #32 to completely undress herself. Continued interview confirmed the staff had difficulty keeping up with resident #21 with all the nursing duties to care for other residents. Continued interview confirmed resident #21 was aggressive and attempting to redirect the resident was difficult especially on the female hall, where the resident liked to wander. Continued interview confirmed the LPN was aware of one incident in the dayroom in which resident #21 struck another male resident who was attempting to give a doll	N 424	• **The social worker completed a PHQ9 assessment on 3/31/2012 to assess resident # 6 and res. # 35 for signs and symptom of depression and to identify possible changes in signs and symptoms of mood distress since his last assessment. The assessments revealed that there was no change from the residents 'baseline** • **(The PHQ-9 is a 9 item patient health questionnaire. A validated interview that screens for symptoms of depression. It provides a standardized severity score and a rating for evidence of a depressive disorder. The total severity provides a standard of communication with clinicians and mental health specialist.)** • **.The charge nurse completed a Skin assessments on resident #6 on 3/18/2012; 3/22/2012 and 3/26/2012.There was no indication of bruising or redness anywhere on the resident body.** • **The care plan was updated for res. # 6 by social services, MDS Coordinator, Social Worker and Quality Assurance Nurse and Sr. Director of clinical services on 03/31/2012 to reflect the need to notify the MD and social**	Completion Date 4/11/12

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N 424	Continued From page 7 to a female resident (witnessed by staff as they were walking by the dayroom) and one incident where another male resident (no longer residing in the facility) reported resident #21 had entered the resident's room and struck him. Medical record review of the nursing notes for January 2012, for resident #32 revealed no documentation of an incident with resident #21 exiting the room. Review of the nursing notes for January 14, 2012, at 10:50 a.m., revealed, "Res (resident) (resident #32)having questionable bleeding from rectal area. MD (physician) notified ...Send res to ER (emergency room)..." Medical record review of the Psychiatric Notes for resident #21 dated January 17, 2012, revealed, "...staff report that resident continues to have a preoccupation with female residents. He has been found in a female resident's bed in the past. He is always pushing their with C's (wheelchairs) or holding hands with various other residents. Staff are concerned this could escalate into a problem and wonder if depo-provera might be a possibility...he (resident #21) denies the above behaviors..." Medical record review of the Nurse's Notes dated January 18, 2012, at 3:45 p.m., revealed, "...CNA (Certified Nurse Aide) came to this nurse and reported finding (resident #21) in (room number) with him exiting the doorway, female residents brief undone & (and) her positioning vest off her body. CNA directed male resident back up hallway & redressed female resident..." 4:30 p.m., "Nurse practitioner psych (psychiatric) ordered Depo Provera (hormonal medication to treat sexual behaviors) IM (intramuscular) once a month for sexual behaviors..."	N 424	**services of changes in mood and behaviors.** **• The Corporate Quality Assurance Nurse and the Sr. Director of clinical services immediately notified the charge nurses on duty of the changes made to the care plan. Changes in resident care are then discussed during nursing shift change.** **• The Director of Nursing updated resident care guides to ensure the nursing assistants were aware of the care plan changes on 4/11/2012 for res. # 6.** **• The care plan for res. # 35 was updated on 4/2/2012 with a new intervention to Place the resident on one on one observation and notify the M.D. and social services when the resident becomes aggressive with other residents. Charge nurses will place resident's on one to one observation and notify the MD and social services when any resident displays aggression of any type toward another resident. The charge nurse and or nursing supervisor will assign a staff member to monitor a resident needing one on one observation. One on one observations are documented on a nurses note or an observations form. The observations are filed in the medical record at the end of each shift.**	Completion Date 4/1/12

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N 424	Continued From page 8 Medical record review revealed no new interventions were implemented for increased supervision of resident #21. Medical record review of the Nurse's Notes dated January 19, 2012, at 6:15 p.m., revealed, "While walking down hallway on long hall 2nd TN (Tennessee) looking for (resident #21) noticed a white sock in doorjam of rm (room). Upon entering room, (resident #21) was in bed A of room...along with female resident (resident #35). Female resident was fully clothed, not seeming to be disturbed by incident. (Resident #21) immediately started to rise out of bed at bottom of bed. His trousers were off, underwear on. He was told to put his pants on & exit room and was sent to dayroom...Female resident (resident #35) was fully clothed in gown, brief on & intact. Covers off resident...(resident #21) was checked every 15 minutes as to his location throughout pm shift..." Medical record review revealed no new interventions were implemented for increased supervision of resident #21. Medical record review of the Mental/Behavioral Health Progress Notes for resident #21 dated January 19, 2012, revealed, "...(Nursing staff requested this therapist visit w/ patient due to boundary issues: Pt (patient) entering other residents rooms at times, requiring some redirection)...asked Pt if he was aware of a problem involving a resident entering other residents' rooms causing some problems. Pt admitted that 'he had done this a couple of times by mistake and that he didn't mean to, adding a vague and superficial reason.' This Thx (therapist) provided Confrontive Therapy in stating that Pt was oriented to location to his	N 424	**2. How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken?** **A side r\ail audit was completed on 100% of the beds in the facility to ensure there was no opportunity for entrapment. The audit began and ended on 3/30/2012.** **The audit was completed by the Charge Nurses, DON, ADON, Corporate Quality Assurance Nurse, and the Corporate Director of Clinical Services on 3/30/2012.** **A total of nine beds were replaced. Skin assessments were completed by** Completion Date 4/1/12 **the charge nurses on all residents on 2nd Tennessee beginning 3/30/2012 through 4/4/2012 to identify unknown bruises and or abrasions.** • **All residents on 2nd Tennessee may be affected by the same alleged deficient practice. However to ensure a safe environment for all residents who live on 2nd Tennessee Resident #21 was transferred to Bristol Regional Medical Center for an evaluation and placement to a behavior unit on 3/30/2012 at 4:00pm.**	

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N 424	Continued From page 9 room. Pt replied that he was. Pt replied that he would not enter other residents' rooms...reiterated boundary issues...clarifying loneliness in (is) no excuse. Adequate understanding - implementation remains questionable...often confused w/ some illogical thinking, poor judgment, some delusions..." Medical record review of the Psychiatric Notes for resident #21 dated January 24, 2012, revealed, "...Staff report that resident continues his pursuit of female residents. They do not feel it is sexual but more of wanting to lay beside them probably because he misses his wife however there have been several close calls recently and staff have noticed that he will take a piece of paper or a sock and put it in the door while he is inside with a female resident, he is currently on Q-15min (every 15 minutes) checks so staff are aware of his where-abouts at all times..." Medical record review of the Mental/Behavioral Health Progress Notes dated January 31, 2012, revealed, "...Re-emphaiszed w/ Pt the importance of not entering anyone else's room. Pt agreed..." Medical record review of the Nurse's Notes dated February 4, 2012, at 6:25 p.m., revealed, "This resident came and told nurse that female resident was in the floor and pointed down hallway - nurse went to (check) and found female resident in her room on buttocks. Female resident said this resident (resident #21) tried to stand her (up) from side of bed and she slid to fall in floor. Residents separated. This resident (resident #21) monitored closely for wandering..." Review of the IDT (Interdiscliplinary Team) recommendations for the incident February 4, 2012, revealed, "...Psych svc (psychiatric	N 424	• **On 3/30/2012 members of the quality assurance committee, Director of Nursing, Assistant Director of Nursing and or the Chief Executive, Corporate Director of clinical services reviewed the Staffing levels on 2nd Tennessee and decided to increase staffing by 43% (4- staff members) on the 7A-7P shift and increased by 25% (2 staff members) on the 7P -7A shift. Staffing will be increased to six nursing assistants on the 7A-7P shift and five nursing assistants on the 7P – 7A shift as soon as the facility can maintain the new staffing levels. This will be a permanent change.** • **To increase and retain the increased number of staff on 2nd Tennessee the facility has placed a newspaper ad locally, on Craig's list and, on Monster.com for** C.N.A'.s, LPN'.s and RN's. • **Offering a $500.00 new hire sign on Bonus for LPN's and C.N.A.'s.** • **Offering a $250.00 referral Bonus to current employee that refers other nursing staff that are hired and stay past ninety days.** • **A perfect attendance Bonus of an additional twenty-five cent per hour worked per pay period has been implemented for nursing assistants.** **All staff will receive education on:**	Completion Date 4/11/12

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N 424	Continued From page 10 services) to follow r/t (related to) (increased) behaviors..." Medical record review revealed no new interventions were implemented for increased supervision of resident #21. Medical record review of the Nurse's Notes dated February 5, 2012, at 4:30 p.m., revealed, "Resident observed via staff, hitting another in head (with) fists. Redirection provided to residents..." Review of the IDT recommendations for the incident February 5, 2012, revealed, "...Notified psych svc; monitor closely..." Medical record review revealed no new interventions were implemented for increased supervision of resident #21. Medical record review of the Nurse's Notes dated February 7, 2012, at 2:10 p.m., revealed, "Another resident reported to me that (resident #21) slapped him across the face. They were in the hall (long) on 2nd TN. (Resident #21) has no recollection of any events and when questioned he repeats numerous stories about the events..." Review of the IDT recommendations for the incident February 7, 2012, revealed, "...psych to follow..." Medical record review revealed no new interventions were implemented for increased supervision of resident #21. Medical record review of the Nurse's Notes dated February 8, 2012, at 10:30 a.m., revealed, "IDT review of altercation on 2/7/12 ...MD (Medical	N 424	• **Managing residents with Dementia and Dementia related behaviors including residents who wander. Contracted Hospice provider is scheduled to provide the above training. The training began on 4/5/2012 and will be completed by April 11, 2012.** • **Implementation of interventions to prevent a behavior. Contracted Hospice provider is scheduled to provide the above training. The training began on 4/5/2012 and will be completed by April 11, 2012. Implementation of interventions after a behavioral event has occurred. Contracted Hospice provider is scheduled to provide the above training. The training began on 4/5/2012 and will be completed by April 11, 2012. The training also included a review of the facility policy** on Behavior assessment and monitoring by the Assistant Director of Nursing. • **The Corporate Sr. Director of clinical Services, corporate Quality Assurance Nurse and or Director of Nursing will educate all staff on the types of abuse, the policy and procedure for reporting and investigating abuse, Sexual behaviors** and possible sexual abuse. The training began on 4/ 4/2012 and will **end on 4/11/2012. This training also included mandatory reporting of the Elder Abuse Act**	Completion Date 4/11/12

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N 424	Continued From page 11 Doctor) was notified. Will have psych follow..." Medical record review of the Mental/Behavioral Health Progress Notes dated February 7, 2012, revealed, "...(Nursing staff advised this therapist that there had been another behavioral incident w/ patient involving another resident)...asked Pt how he was getting along w/ others...replied was doing fine...denied having any problems...denied having any incidents or altercations w/ other residents...replied that he was an honest man and assured good behavior...not w/out (without) confusion, and some delusional thinking at times..." Medical record review of the Nurse's Notes dated February 16, 2012, at 5:00 p.m., revealed, "A family member approached the nurses station (with) clothes in...hand and made reference that one of the residents in the dayroom took...father's clothes and stole his socks, while...attempting to write...father's name in them...said 'That man scratched me'...then identified (resident #21)..." Medical record review of the Social Service Progress Notes dated February 16, 2012, revealed, "Care Plan Review...Behavior concerns discussed as related to how resident wants to help others - i.e. (that is) transfers, etc. (etcetera) - will cont. (continue) to monitor..." Medical record review of the Nurse's Notes dated March 1, 2012, at 4:30 p.m., revealed, "This resident struck male resident in his back (with) his fist (per CNA) no visible injury noted - residents separated. Staff monitoring..." Review of the IDT recommendations for the incident March 1, 2012, revelaed, " ...IDT follow-up - resident attempt to harm other	N 424	• **All staff who missed the in-service will be in-serviced by the staffing coordinator and or the corporate Quality assurance nurse prior to being allowed to work the floor. The facilities do not use agency staff.** • **The Director of Nursing, Assistant Director of Nursing and or the Chief Executive Director will investigate all allegations of abuse as soon as they are made aware of the allegation and will report the allegations and the findings of the investigation to the appropriate state agencies.** • **The interdisciplinary team (Administrator, Director of Nursing, Assistant Director of Nursing, Medical Director, Business Office Manager, Dietary Manager, Activities Director, Social Services Director, and Therapy Manager) will review all allegations of abuse in the daily clinical meeting and in the monthly Quality Assurance meeting.**	

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N 424	Continued From page 12 resident ...Residents separate no futher aldercation (further altercation) until 3-9-12 aggitated toward male resident ..." Medical record review revealed no new interventions were implemented for increased supervision of resident #21. Medical record review of Daily Progress Notes from the FNP (Family Nurse Practitioner) dated March 7, 2012, revealed, "...Does not want exam! Foul language...Dementia (with) behavioral issues..." Medical record review of the Nurse's Notes dated March 9, 2012, at 1:00 p.m., revealed, "Reported to this nurse by CNA. This resident (resident #21) was in dayroom and walked up to another male resident (resident #35) that was talking to a female resident. This resident (resident #21) hit male resident (resident #35) in face (with) his fist - Residents separated - this resident (resident #21) agitated and kept trying to go toward male resident (resident #35) he hit - staff intervened...2pm This resident (resident #21) walked up to the same male resident (resident #35) and hit him with his fist again while other male resident (resident #35) was at elevator-residents separated by staff...2:20 pm...Resident (resident #21) transported via ambulance to (named hospital)...7 pm Returned to (facility). DON (Director of Nursing) aware...Will monitor behavior..." Medical record review of the Social Service Progress Notes for resident #21 dated March 9, 2012, "Attempted referral to 5-E (psychiatric unit) - transported to hospital...aggressive behavior toward another individual..." Medical record review revealed the resident returned from the	N 424		

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N 424	Continued From page 13 ER on March 9, 2012, at 7:00 p.m. Review of the IDT recommendations for the incident for March 9, 2012, revealed, " ...Residents separate no futher aldercation (further altercation) (referring to March 1, 2012 altercation) until 3-9-12 aggitated toward male resident...SSD (Social Services Director) and Clinical Staff attempting to locate geripsych units to place resident...Will continue to observe behaviors...3/12/12 ...behavior toward other resident...3/19/12 Exhibits 0 behavior @ (at) present..." March 28, 2012, (for March 27) "...Medication changes made...Psych services notified of behavior...IDT will follow up in 5-7 days..." Medical record review revealed no new interventions were implemented for increased supervision of resident #21. Medical record review of the Nurse's Notes dated March 10, 2012, at 4:00 p.m., revealed, "...Required redirection x4 (times four) from others rm (room) or locations not intended for residents. Resident with several layers of clothing on several times this day. Not all belonging to him. Staff removed..." Medical record review of the Social Service Progress Notes dated March 12, 2012, revealed, " ...Staff review ...referral for Pscy eval. Treatment - Psyc Unit." Further review revealed March 12, 2012 was the last documentation in the Social Services notes. Medical record review of the Nurse's Notes dated March 13, 2012, at 11:00 a.m., revealed, "...He was seen throwing a shoe at another res this AM..."	N 424		

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N 424	Continued From page 14 Medical record review of Daily Progress Notes from the FNP dated March 13, 2012, revealed, "Pt (patient) to ER (emergency room)...severe agitation..." Medical record review revealed the ER visit was March 9, 2012, from 2:20 p.m., until 7:00 p.m. Medical record review of the Mental/Behavioral Health Progress Notes dated March 15, 2012, revealed, "...(Nursing staff requested this therapist visit w/ Patient due to some boundary issues and some behavioral problems)...Pt related getting along alright, having no problems...Since Pt denied having any problems. Confrontive Therapy necessary relative to Pt's intruding into other residents' rooms. Pt stated that he gets a little confused at times. This Thx countered w/ Pt's ability to find his own room...Pt said he would remember to do this, he added that he is a nice man and does not want to cause problems..." Medical record review of the Nurse's Notes dated March 27, 2012 at 6:30 p.m., revealed, "Res has been (up) walking around facility. Res pushing some of the women res around unit in their w/cs (wheelchairs). Res re-directed to lobby (without) difficulty. 0 (no) apparent behavior/anger problems noted..." Medical record review of the Mental/Behavioral Health Progress Notes dated March 22, 2012, revealed, "...Pt related feeling a little anxious and depressed, stating some things were bothering him...replied that there was minor argument w/ another resident recently that had upset Pt. Pt unable to provide much in the way of details, somewhat vague and superficial..." Review of the Mental/Behavioral Health progress notes revealed no recommendations for staff to	N 424		

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N 424	Continued From page 15 manage or monitor the resident's behaviors. Observation and interviews on March 27, 2012, from 8:10 p.m., until 9:00 p.m., on 2nd TN, revealed resident #37 was heard in the hallway screaming "help me." Observation and interview with resident #37 in the resident's room at 8:15 p.m., revealed resident #37 stated resident #21 had entered the resident's room, was going through the top drawer of a dresser and when resident #37 attempted to stop resident #21 from going through personal belongings, resident #21 "threw me up against the wall" and was cussing at resident #37 telling resident #37 to get out of his room. Interview revealed resident #37 went out to the hall to yell for help and resident #21 kicked resident #37. Resident #37 stated did not want to fight with resident #21, but "he's dangerous." Further observation revealed, after the altercation, resident #21 was directed by staff and ambulated to the dayroom and left to sit in a chair, with no staff present in the dayroom. Continued observation in the dayroom revealed, at 8:53 p.m., resident #21 went to resident #35 striking at the resident (unable to see if actual physical contact was made) and another resident yelled at resident #21 to stop, staff then entered the dayroom and directed and ambulated resident #21 down the hallway, out of the dayroom. Interview with CNA #4 on March 27, 2012, at 8:50 p.m., in the 2nd TN pantry, confirmed some of the residents on the unit were up all night wandering and interventions for residents with behaviors was to redirect the residents to the dayroom. Continued interview confirmed the CNA spent most of the evening redirecting residents and it was hard to keep up with all the residents.	N 424		

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N 424	Continued From page 16 Medical record review of the nurse's notes documented the night of March 27, 2012, at 11:00 p.m., (the night resident #21 was observed kicking resident #37 and striking at resident #35) revealed, "Res (resident #21) has been (up) walking around facility - 0 complaint or indication of pain. Res redirected to lobby (without) diff (difficulty). 0 apparent behavior/anger problems..." Medical record review of the nurse's notes dated March 28, 2012, at 9:25 a.m., revealed, "Res (resident #21) up walking around dayroom. Res walked over to male res in dayroom started fussing about him messing with the woman in there. Other resident unaware of why this res is fussing @ (at) him. Resident's separated..." Medical record review of the nurse's notes dated March 29, 2012, revealed, "Late entry for 3/27/12 at 7:30 pm. Nursing assisted another resident to their room when (resident #37) came out of his room yelling "help me." (Resident #21) was then seen coming out of (resident #37) room. (Resident #21) was yelling at (resident #37) and then proceeded to kick (resident #37) in the buttocks. (Resident #21) was then assisted to the dayroom..." Review of the IDT recommendations for the incident for March 27, 2012, revealed, "...Medication changes made...Psych services notified of behavior...IDT will follow up in 5-7 days..." Medical record review of Daily Progress Notes for resident #21 from the FNP dated March 28, 2012, revealed, "...having aggressive behaviors hitting..."	N 424		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 424	Continued From page 17 Observation of resident #21 on March 29, 2012, at 10:37 a.m., on the 2nd TN hallway revealed the resident was pushing resident #17 down the hallway in a wheelchair, a CNA stated "are you going to be nice to her," allowing the resident (resident #21) to continue to push the resident (resident #17). Continued observation revealed Licensed Practical Nurse (LPN) #4 intervened by taking resident #21 to the dayroom, sitting the resident in a chair and leaving the resident there with no staff present. Continued observation revealed the resident stated, "They aren't going to stop me. They are taking my rights away." Continued observation at 10:45 a.m., revealed resident #21 was again pushing resident #17 down the hall in a wheelchair when LPN #4 stated "(resident's name) will you let her go..." and resident #21 was redirected away from resident #17 who was taken to a room. Interview with CNA #2 on March 30, 2012, at 9:05 a.m., at the 2nd TN nursing station, confirmed resident #21 had wandering behaviors, was very protective of female residents, liked to crawl into bed with female residents, had been "fondling women last few months...any woman - no one in particular...I think he knows more than he lets on. He knows what he is doing." Continued interview confirmed the resident had been found in bed, without clothes on, with one female resident; had a several month history of aggressive behaviors with some residents, particularly resident #35; had a history of hitting residents; and the aggressive behaviors had been ongoing for at least the last couple of months. Continued interview confirmed "He is like this every day with females and maybe every other day with (resident #35)." Continued interview confirmed interventions are to separate the residents, redirect them, and talk to them about what is	N 424		

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N 424	Continued From page 18 appropriate and inappropriate. Continued interview confirmed resident #21 was on every 15 minute checks before he was sent to the hospital last time, but that was the last time the CNA recalled. Continued interview confirmed "Really, really hard to keep up with him some days when there are only three CNAs here on the floor." Interviews with LPN #6, LPN #7, and the Social Services Director (SSD) on March 30, 2012, at 9:25 a.m., and 10:00 a.m., at the 2nd TN nursing station, confirmed resident #21 had a history of aggressive behaviors, which had been worsening since the resident's ex-spouse died in November, 2011, and he associated other female residents with his wife/ex-wife. Continued interviews confirmed the resident was difficult to redirect at times and if interventions did not work, the resident had been placed on either every 15 minute checks or one to one supervision in the past. Continued interviews confirmed the facility sent the resident to the emergency room and attempted to have the resident admitted to a psychiatric facility March 9, 2012, when the resident hit resident #35 two times in a one hour period, but the resident returned to the facility without being admitted. Continued interview confirmed the resident was only put on every 30 minute checks upon returning from the hospital. Continued interviews confirmed when the resident was having escalating aggressive behaviors the staff managed the resident's behaviors by checking where the resident was every 30 minutes and redirecting the resident to the dayroom if found in other resident's rooms. Continued interviews confirmed the resident had not been placed on one to one supervision or every 15 minute checks since "way before" the attempt at psychiatric admission March 9, 2012. Continued interviews confirmed there were times	N 424		

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N 424	Continued From page 19 resident #21 needed to be on one to one supervision or every 15 minute checks, for the safety of other residents, but the unit did not always have available staff to monitor the resident more frequently than every 30 minutes. Interviews confirmed the only time nursing had called the SSD for intervention was March 9, 2012, to send the resident to the ER. Continued interviews confirmed the resident had hit several different male residents over the last few months. Continued interviews confirmed unit managers were aware resident #21 had a physical altercation with resident #35 on March 27, 2012, and no changes were made in to increase the supervision of resident #21. Interviews with resident #38 and LPN #7 on March 30, 2012, at 9:40 a.m., at the 2nd TN nursing station, revealed the LPN stated resident #38 (female resident) was a reliable source of information and wanted to report an incident concerning resident #21. Interview with resident #38 revealed the resident was awakened early that morning with resident #21 standing over resident #38's bed, and resident #21 "scared" resident #38 causing resident #38 to slap resident #21's arm. Resident #38 stated resident #21 came to resident #38's room "more than I like" and resident #38 stated "I don't like it." LPN #7 confirmed staff were unaware resident #21 had been in resident #38's room. Medical record review of the an assessment for resident #38 dated February 19, 2012, revealed the resident scored 14 out of 15 on the BIMS, indicating no cognitive impairment. Medical record review of the Nurse's Notes for March 30, 2012, revealed resident #21 was on every 15 minute observations and the following	N 424		

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N 424	Continued From page 20 documentations, "...10:45A (a.m.)...Resident talking about women being with other men talking about I think my wife had 3-4 other men. Resident talking about resident female as if it was his late wife...12:00P (p.m.)...calm until meeting other male resident mumbled a few words to (resident name) then walked away..." Interview with the Activities Director (AD) on March 30, 2012, at 10:38 a.m., in the conference room, confirmed the AD had noticed resident #21's behaviors had become worse "lately" and the resident had particular issues with resident #35, who resident #21 feels is the person who assaulted him in the past. Interview confirmed the resident picks various females and thinks they are his wife or girlfriend. Further interview confirmed the resident had always been difficult to occupy with activities, which would sometimes work and sometimes not work, depending on the resident's mood, but the AD had noticed the resident was refusing to participate in any activities more lately. Continued interview confirmed the AD had seen the biggest change in the last week and "This is the worse I have seen him." Observation of resident #21 and interview with the Assistant Director of Nursing (ADON) and Corporate Quality Assurance Nurse on March 30, 2012, from 3:51 p.m., until 4:02 p.m., on 2nd Tennessee, confirmed resident #21 had been on one to one or every 15 minute checks since 10:30 a.m., and was currently on one to one supervision, due to safety concerns for the other residents, and the resident was transferred to the hospital at 4:02 p.m., for evaluation and treatment of behaviors. Interview with CNA #1 on March 30, 2012, at 4:15	N 424		

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N 424	Continued From page 21 p.m., outside the 2nd TN shower rooms, confirmed "they all wander, they don't know where they are" and staff redirect the residents. Telephone interview with the Psychiatric Nurse Practitioner (NP) on March 30, 2012, at 4:45 p.m., confirmed the NP had been treating resident #21 in conjunction with a clinical psychologist since the resident's ex-spouse died in November, 2011. Continued interview confirmed they were unsure if the psychotherapy actually worked but the psychologist provided therapy for the resident, and provided the NP with progress reports so the NP could manage medications. Continued interview confirmed the resident suffered a very accelerated decline in which the resident was more confused, sexually aggressive, was going into other resident's rooms, and was aggressive towards males. Continued interview confirmed the NP had been informed the resident had "Last night" gone into a resident's room and slapped, kicked, and pushed a resident. Continued interview confirmed when the resident's ex-wife died the sexual behaviors began with the resident wanting to be with female residents and kiss female residents. Continued interview confirmed the NP was only familiar with the one incident in January when the resident was found in bed with a female resident with her fully clothed and he with his pants off and underwear on. Continued interview confirmed the resident had exhibited other sexual behaviors such as being found in the female resident's room "with a sock placed in the door jam." Interview confirmed the NP thought medication interventions were needed to decrease the sexual behaviors, but depo-provera takes three months or more to show symptom improvement and "you do have to worry about other females." Continued interview confirmed the resident has	N 424		

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N 424	Continued From page 22 had altercations and physical aggressiveness towards other male residents. Continued interview confirmed needed supervision to protect other residents until medication adjustments took effect. Telephone interview with resident #21's physician on March 30, 2012, at 6:20 p.m., confirmed the resident had been "intermittently violent" and the physician had on two other occasions sent the resident to the emergency room for evaluation and admission to a psychiatric unit, but the resident was returned to the facility without being admitted. Further interview confirmed the physician had been trying to have the resident admitted to a psychiatric unit due to the need for more intense monitoring and management of behaviors. Continued interview confirmed staff needed "to keep an eye on him" when the resident was violent. Continued interview confirmed the physician thought the nurses placed the resident on at least every 15 minute or one to one observations until the resident calmed down, which would be appropriate for the resident. Interviews with the Social Services Director and the Senior Director of Clinical Operations on March 30, 2012, at 10:45 a.m., in the Assistant Director of Nursing (ADON's) office, confirmed facility staff were aware of resident #21's aggressive behaviors and having hit other residents including resident #35. Continued interviews confirmed visual checks to locate the resident were to be done every thirty minutes, but the resident was capable of hurting other residents in a thirty minute time frame. Continued interviews confirmed the facility had just implemented every 15 minute monitoring to ensure the safety of other residents.	N 424		

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N 424	Continued From page 23 Resident #35 was admitted to the facility May 17, 2011, with diagnoses including Dementia with Behavior Disturbance, Mental Disorder, Delusional Disorder, Encephalopathy, Schizoaffective Disorder, and Generalized Anxiety. Medical record review of the Minimum Data Set (MDS) dated January 29, 2012, revealed the resident had impaired short and long term memory, had moderately impaired cognitive skills for daily living with inattention, disorganized thinking, and was short tempered and easily annoyed. Further review of the MDS, revealed the resident was ambulatory with steady gait, used no mobility devices, and exhibited wandering behaviors daily. Medical record review of the Nurse's Notes dated February 29, 2012, at 7:30 p.m., revealed the resident (#35) "...walked into dayroom where female resident (#6) was sitting in WC (wheelchair). Resident (#35) put...(resident's) hands around female resident's neck and was trying to choke...(female resident)..." Continued medical record review revealed the resident (#35) was redirected to his room and the facility provided no increased supervision for resident (#35). Medical record review of the Nurse's Notes dated March 20, 2012, at 10:00 a.m., revealed "...res (resident) grabbed side of geri-chair and tipped chair over on its side with another res reclined in chair...stating these people aren't paying their dues..." Continued medical record review revealed the facility provided no increased supervision for the resident (#35).	N 424		

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N 424	Continued From page 24 Medical record review of the Nurse's Notes dated March 24, 2012, at 2:00 p.m., revealed "...x (times) 1 episode of verbal and physical threatening of visitor in rm (room) with rm. mate..." Medical record review of a Psychiatric Note Initial Psychiatric Consultation, dated February 14, 2012, revealed "...confusion, as typical for... (resident) does not answer very many questions, tends to mumble and attempt to walk away during interview, staff report little more aggression toward staff and other residents most recently..." Continued medical record review of a Psychiatric Note, dated February 28, 2012, revealed "...staff...resident... is talking more although... (resident's) thoughts are irrational...also stands at nurse station all day attempting to carry on a conversation with staff...continues to get down in the floor often..." Further medical record review of a Psychiatric Note dated March 27, 2012 revealed "...staff report resident continues with... (resident's) agitation on occasion...is extremely confused today and seems agitated...(staff) also say...(resident) continues to get extremely agitated and combative with staff at times and is usually out of the blue..." Medical record review of the Care Plan dated June 3, 2011 through April 12, 2012, revealed no Care Plan for potential or actual aggressive behaviors for the resident. Observation on March 26, 2012, at 10:00 a.m., revealed the resident standing at the 2nd Tennessee Nurse's Station, confused, with a clip board in hand, making a statement about something that had not been done. Observation on March 27, 2012, at 3:00 p.m.,	N 424		

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N 424	Continued From page 25 revealed the resident wandering unattended on the 2nd Tennessee Short Hall, (the women's hall) with no staff present. Telephone interview with the Psychiatric Nurse Practitioner (NP) on March 30, 2012, at 4:45 p.m., confirmed the resident #35 was "very psychotic" and resident #35 had aggressive behaviors. Observations of the residents and staff on 2nd TN and interviews with staff during observations from March 26 through March 30, 2012, revealed staff were not always available or in sight of the dayroom to supervise residents; staff were not always aware residents had wandered into other resident rooms; and staff confirmed there was not enough staff available to provide care for dependent residents and to supervise wandering residents and residents with behaviors. Resident #8 was re-admitted to the facility on February 16, 2012, with diagnoses including Left Hip Fracture, Diabetes Mellitus Type II, and Dementia. Medical record review of the MDS dated March 8, 2012, revealed the resident was unable to complete the BIMS, had long and short term memory problems, had moderately impaired cognition, and was totally dependent on all staff for activities of daily living. Observation of the resident on March 27, 2012, at 3:54 p.m., in the resident's room, and interview with LPN #4, in the resident's room, confirmed the resident was lying in bed, and the full bed rails of the bed, which were both elevated, shifted at the foot of the bed causing a gap between the resident's mattress and the bed rails. Continued	N 424		

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N 424	Continued From page 26 observation and interview confirmed the gap between the side of the mattress and bed rail was approximately "hand size" (measuring from fingertip to base of palm) and the gap created would shift to either the left or right side of the bed if pressure was applied to the bed rails, moving them. Further interview confirmed the resident was capable of the moving the legs and feet in the bed and the gap was a safety hazard for the resident. Interview confirmed maintenance would be called to repair immediately. Observation of the resident on March 27, 2012, at 8:00 p.m., in the resident's room, revealed the resident was lying in bed, sleeping, full bed rails on both sides of the bed were elevated, the head of the bed was elevated approximately 45 degrees. The resident was leaned towards the left side, against the side rails. Further observation revealed the weight of the resident compressed the mattress, and with the head of the bed elevated, a gap created between the top of the mattress and the space in the full side rail bars was large enough for the resident's arm to the shoulder area to fit through the space. Further observation revealed the gap at the foot of the bed was still present and the bed rails shifted as observed at 3:54 p.m. Observation and interview with the Senior Director of Clinical Services on March 27, 2012, at 8:26 p.m., in the resident's room, confirmed the bed rails were a safety risk and were immediately removed. Resident #17 was admitted to the facility on October 28, 2011, with diagnoses including Intracranial Injury, Facial Fractures, Dementia, Abnormality of Gait, Muscle Weakness, Failure to	N 424		

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N 424	Continued From page 27 Thrive, and Senile Cachexia. Medical record review of the Minimum Data Set (MDS) dated January 22, 2012, revealed the resident required extensive assistance with decision making, had short and long term memory loss, and was totally dependent for activities of daily living. Observations on March 26, 2012, at 2:52 p.m., 3:00 p.m., 4:18 p.m., and 4:23 p.m., March 28, 2012, at 2:15 p.m., and March 29, 2012, at 8:00 a.m., 8:38 a.m., and 1:44 p.m., revealed the resident was constantly rolling in and out of other resident's rooms without redirection or being engaged in any activity by staff. Observation on March 26, 2012, at 3:01 p.m. to 3:06 p.m., revealed the resident was in another resident's room with the door shut. Continued observation revealed the resident was sitting in a wheelchair with the bottom drawer of the bedside table belonging to the resident in B bed opened. Continued observation revealed resident #17 retrieving another resident's jewelry from a bedside table and placing it on the left ankle. Interview with Certified Nursing Assistant (CNA) #1 on March 26, 2012, at 3:10 p.m., on 2nd Tennessee hallway, stated the resident would be taken to the second floor day room, "like I have done ten times today". Observation at that time revealed the resident was rolled out of the room and placed in the middle of the 2nd Tennessee day room by CNA #1, where the wheelchair was locked. CNA #1 exited the day room and the resident was not engaged in any activity with no staff present.	N 424		

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N 424	Continued From page 28 Observation on March 26, 2012, at 3:19 p.m., in the 2nd Tennessee day room, revealed the resident sitting in a wheelchair with the shirt off and no bra on and no staff was present. Observation on March 26, 2012, at 4:23 p.m., revealed resident #17 was coming out of another resident's room and the staff redirected the resident toward the second floor nurses station. Continued observation revealed the resident then turned the wheelchair around and rolled into another resident's room and the resident in that room told the resident to "go out". Observation on March 27, 2012, at 8:00 p.m., revealed resident #17 going into another resident's room, turning overhead lights on, pushing bed of the resident against the wall, while this resident was lying in the bed asleep. Continued observation revealed the resident exited that room and went into another resident's room where this resident called out in a loud voice, "get (resident) out of here". Continued observation revealed the resident was taken to the 2nd Tennessee day room and not engaged in any activity and was left unattended. Continual observation of the 2nd Tennessee unit on March 29, 2012, from 7:32 a.m. to 7:46 a.m., revealed the resident was not in resident's room, hallways, shower room, or day room. Continued observation revealed staff was unaware of where the resident was and was unable to locate the resident. Observation and interview on March 29, 2012, at 7:46 a.m., revealed Licensed Practical Nurse (LPN) #7 located the resident in another resident's room. Continued observation revealed the resident sitting in a wheelchair with the head	N 424		

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N 424	Continued From page 29 lying on bed of the resident in B bed. Continued observation revealed the resident was rolled by staff into the short hallway and was not redirected or engaged in any activity. LPN.#7 confirmed staff was unaware of where the resident was prior to finding the resident in another resident's room and "this was a concern".	N 424		
N 602	1200-8-6-.06(1)(b)1. Basic Services (1) Performance Improvement. (b) The performance improvement program must be ongoing and have a written plan of implementation which assures that: 1. All organized services related to resident care, including services furnished by a contractor, are evaluated; This Rule is not met as evidenced by: Based on medical record review, observation, review of facility documentation, interview, and review of facility policy, the facility Quality Assurance (QA) program failed to ensure effective systems were in place to identify and investigate incidents of abuse allegedly perpetrated by one resident (#21); to formulate and implement a behavior care plan for one resident (#21) with behaviors; and failed to identify staffing needs to provide supervision of aggressive/abusive behaviors for two residents (#21 and #35) with behavioral problems. The facility's failure to ensure the Quality Assurance Committee identified issues and addressed plans of correction to ensure incidents of possible abuse were investigated; behavior care plans were implemented; and supervision of	N 602	***The following corrective action was completed for each resident found to have been affected by the alleged deficient practice*** • **On 3/30/2012 members of the quality assurance committee, Director of Nursing, Assistant Director of Nursing and the Chief Executive Officer, Corporate Director of clinical services and Corporate Quality Assurance Nurse had an informal quality assurance meeting to develop a plan to stop the immediacy of the Jeopardy. The following plan was put in place:** • **The Staffing levels on 2nd Tennessee were increase staffing by 43% (4- staff members) on the 7A-7P shift and increased by 25% (2 staff members) on the 7P -7A shift.**	

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N 424	Continued From page 29 lying on bed of the resident in B bed. Continued observation revealed the resident was rolled by staff into the short hallway and was not redirected or engaged in any activity. LPN.#7 confirmed staff was unaware of where the resident was prior to finding the resident in another resident's room and "this was a concern".	N 424	• Staffing will be increased to six nursing assistants on the 7A-7P shift and five nursing assistants on the 7P – 7A shift as soon as the facility can maintain the new staffing levels. This will be permanent staffing. The DON, ADON, Corporate Quality Assurance Nurse, Corporate Sr. Director of Clinical Services and unit managers assessed all side rails in the facility to ensure there was no one at risk of entrapment. Nine beds were replaced with new beds. • Skin assessments were completed by the charge nurses to identify unknown bruises and or abrasions. • Resident # 21 was placed on fifteen minute observation on 3/30/2012 at 10:30 am until he was transferred to another facility. • Resident #21 was transferred to the Medical Center for an Evaluation and placement to a behavior unit on 3/30/2012 at 4:00pm. The facility will not readmit this resident. • The care plan was updated for res. # 35 by social services, MDS Coordinator, Social Services, Quality Assurance Nurse and Sr. Director of clinical services on 03/31/2012 to reflect the need to notify the MD and social services of changes in mood and behaviors.	Completion Date 4/11/12
N 602	1200-8-6-.06(1)(b)1. Basic Services (1) Performance Improvement. (b) The performance improvement program must be ongoing and have a written plan of implementation which assures that: 1. All organized services related to resident care, including services furnished by a contractor, are evaluated; This Rule is not met as evidenced by: Based on medical record review, observation, review of facility documentation, interview, and review of facility policy, the facility Quality Assurance (QA) program failed to ensure effective systems were in place to identify and investigate incidents of abuse allegedly perpetrated by one resident (#21); to formulate and implement a behavior care plan for one resident (#21) with behaviors; and failed to identify staffing needs to provide supervision of aggressive/abusive behaviors for two residents (#21 and #35) with behavioral problems. The facility's failure to ensure the Quality Assurance Committee identified issues and addressed plans of correction to ensure incidents of possible abuse were investigated; behavior care plans were implemented; and supervision of	N 602		

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N 602	1200-8-6-.06(1)(b)1. Basic Services (1) Performance Improvement. (b) The performance improvement program must be ongoing and have a written plan of implementation which assures that: 1. All organized services related to resident care, including services furnished by a contractor, are evaluated; This Rule is not met as evidenced by: Based on medical record review, observation, review of facility documentation, interview, and review of facility policy, the facility Quality Assurance (QA) program failed to ensure effective systems were in place to identify and investigate incidents of abuse allegedly perpetrated by one resident (#21); to formulate and implement a behavior care plan for one resident (#21) with behaviors; and failed to identify staffing needs to provide supervision of aggressive/abusive behaviors for two residents (#21 and #35) with behavioral problems. The facility's failure to ensure the Quality Assurance Committee identified issues and addressed plans of correction to ensure incidents of possible abuse were investigated; behavior care plans were implemented; and supervision of	N 602	**• On 3/31/2012 Resident #36 showed a change from her previous assessment. During the assessment this resident stated that this is not a good time for her, she is having problems with her daughter and at times she has thoughts that she would be better off dead. The resident stated no when the social worker asked her if she had a plan to harm herself. The social worker notified the nurse of the residents' statement. The nurse notified the MD and obtained an order for a Psychiatric evaluation on 3/31/2012. The nursing staff observed the resident through out the night and Completed thirty minutes observations until the resident was seen by psychiatric services.**	

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N 602	1200-8-6-.06(1)(b)1. Basic Services (1) Performance Improvement. (b) The performance improvement program must be ongoing and have a written plan of implementation which assures that: 1. All organized services related to resident care, including services furnished by a contractor, are evaluated; This Rule is not met as evidenced by: Based on medical record review, observation, review of facility documentation, interview, and review of facility policy, the facility Quality Assurance (QA) program failed to ensure effective systems were in place to identify and investigate incidents of abuse allegedly perpetrated by one resident (#21); to formulate and implement a behavior care plan for one resident (#21) with behaviors; and failed to identify staffing needs to provide supervision of aggressive/abusive behaviors for two residents (#21 and #35) with behavioral problems. The facility's failure to ensure the Quality Assurance Committee identified issues and addressed plans of correction to ensure incidents of possible abuse were investigated; behavior care plans were implemented; and supervision of	N 602	• A skin assessment was completed on resident's # 17; #32; #35; # 36 and #37 to identify the presence of bruising and or redness. There were no bruising or redness of unknown causes identified on any of the residents. • Care plans were updated on resident on resident # 17; 32; ; #35; #36and #37 by social services, MDS Coordinator, Quality Assurance Nurse and Sr. Director of clinical services on 03/31/2012 to reflect the need to notify the MD and social services of changes in mood and behaviors. • The care plan for Resident # 36 care plan was updated by social services, MDS Coordinator Quality Assurance Nurse and Sr. Director of clinical services on 03/31/2012 with refer to Psych services and monitor every thirty minutes until evaluated by psych. Services.	Completion Date 4/1/12

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N 602	1200-8-6-.06(1)(b)1. Basic Services (1) Performance Improvement. (b) The performance improvement program must be ongoing and have a written plan of implementation which assures that: 1. All organized services related to resident care, including services furnished by a contractor, are evaluated; This Rule is not met as evidenced by: Based on medical record review, observation, review of facility documentation, interview, and review of facility policy, the facility Quality Assurance (QA) program failed to ensure effective systems were in place to identify and investigate incidents of abuse allegedly perpetrated by one resident (#21); to formulate and implement a behavior care plan for one resident (#21) with behaviors; and failed to identify staffing needs to provide supervision of aggressive/abusive behaviors for two residents (#21 and #35) with behavioral problems. The facility's failure to ensure the Quality Assurance Committee identified issues and addressed plans of correction to ensure incidents of possible abuse were investigated; behavior care plans were implemented; and supervision of	N 602	*2 . How you will identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken* **All residents on 2nd Tennessee may be affected by the same alleged deficient practice. To prevent a reoccurrence of this alleged deficient practice the following changes has been implemented.** • **On 3/30/2012 members of the quality assurance committee, Director of Nursing, Assistant Director of Nursing and or the Chief Executive, Corporate Director of clinical services reviewed the Staffing levels on 2nd Tennessee and decided to increase staffing by 43% (4- staff members resulting in a 1C.N.A to 7**	

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N 602	1200-8-6-.06(1)(b)1. Basic Services (1) Performance Improvement. (b) The performance improvement program must be ongoing and have a written plan of implementation which assures that: 1. All organized services related to resident care, including services furnished by a contractor, are evaluated; This Rule is not met as evidenced by: Based on medical record review, observation, review of facility documentation, interview, and review of facility policy, the facility Quality Assurance (QA) program failed to ensure effective systems were in place to identify and investigate incidents of abuse allegedly perpetrated by one resident (#21); to formulate and implement a behavior care plan for one resident (#21) with behaviors; and failed to identify staffing needs to provide supervision of aggressive/abusive behaviors for two residents (#21 and #35) with behavioral problems. The facility's failure to ensure the Quality Assurance Committee identified issues and addressed plans of correction to ensure incidents of possible abuse were investigated; behavior care plans were implemented; and supervision of	N 602	• **All staff will receive education on the types of abuse, the policy and procedure for reporting and investigating all incidents of abuse, Sexual behaviors and possible sexual abuse by the Senior Director of Clinical Services with Health Services management group, the Quality Assurance Nurse and or the Director of Nursing by April 11th, 2012. This training also included mandatory reporting of Elder Abuse Act** • **The Director of Nursing, Assistant Director of Nursing and the Chief Executive officer (Administrator) will investigate all allegations of abuse as soon as they are made aware of the allegation and will report the allegations and the findings of the investigation to the appropriate state agencies.**	

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N 424	Continued From page 29 lying on bed of the resident in B bed. Continued observation revealed the resident was rolled by staff into the short hallway and was not redirected or engaged in any activity. LPN.#7 confirmed staff was unaware of where the resident was prior to finding the resident in another resident's room and "this was a concern".	N 424	• **The MDS Coordinators were re-educated on OBRA required MDS assessments and facility required quarterly assessments, care plan development and implementation by the Quality assurance Nurse on 4/5/2012.** • **The interdisciplinary team (Administrator, Director of Nursing, and Assistant Director of Nursing, Business Office Manager, Dietary Manager, Activities Director, Social Services Director, and Therapy Manager) will receive education on OBRA required MDS assessments and facility required quarterly assessments, care plan development and implementation by the Quality assurance Nurse by 4/10/2012.** • **All licensed nurses will receive education on developing Interim care plans for new admissions by 4/11/2012.** The Quality Assurance Nurse, Director of Nursing, Assistant Director of Nursing and or the staff development Coordinator will provide the **education.** • **The Director of Nursing, Assistant Director of Nursing, and unit managers will review medical records** of new admissions in the daily clinical meeting Monday through Friday to **ensure an interim care plan is implemented within twenty-four hours** of admission to the facility.	
N 602	1200-8-6-.06(1)(b)1. Basic Services (1) Performance Improvement. (b) The performance improvement program must be ongoing and have a written plan of implementation which assures that: 1. All organized services related to resident care, including services furnished by a contractor, are evaluated; This Rule is not met as evidenced by: Based on medical record review, observation, review of facility documentation, interview, and review of facility policy, the facility Quality Assurance (QA) program failed to ensure effective systems were in place to identify and investigate incidents of abuse allegedly perpetrated by one resident (#21); to formulate and implement a behavior care plan for one resident (#21) with behaviors; and failed to identify staffing needs to provide supervision of aggressive/abusive behaviors for two residents (#21 and #35) with behavioral problems. The facility's failure to ensure the Quality Assurance Committee identified issues and addressed plans of correction to ensure incidents of possible abuse were investigated; behavior care plans were implemented; and supervision of	N 602		

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N 602	Continued From page 30 residents with aggressive behaviors was provided placed all the residents on the 2nd Tennessee (2nd TN) unit in an environment which was detrimental to their health, safety and welfare. The findings included: Interview with the Senior Director of Clinical Services, Adminstrator, and Regional Vice President on March 30, 2012, at 4:00 p.m., in the Administrator's office, confirmed the facility's QA committe had reviewed behavior issues on the 2nd TN (Tennessee) unit, but had failed to identify any issues requiring a corrective action plan or Performance Improvement project to address behavior issues, supervision, or identification, reporting and investigating incidents/abuse. Refer to 1200-8-6-.04 (15) (N-424) Administration	N 602		
N 669	1200-8-6-.06(4)(c)4. Basic Services (4) Nursing Services. (c) The Director of Nursing shall have the following responsibilities: 4. Notify the resident ' s physician when medically indicated. This Rule is not met as evidenced by: Based on medical record review, observation, and interview the facility failed to notify the physician of significant behaviors for one resident (#21); failed to notify the physician of a significant incident for one resident (#32); and failed to notify the physician of elevated blood sugars, and	N 669	**1. What corrective actions(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?** **• The physician was notified of the residents' blood sugar results of 357 on 3/16/2012 and 476 on 3/23/2012 by the unit manager on 1st Tennessee on 4/09/2012. There were no new orders given.** **• The Physician was notified by the ADON on February 14, 2012 of the recommendation to increase Buspar from 10mg every day to 7.5 TID. The ADON obtained an order for the recommended change.**	Completion Date 4/11/12

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N 669	Continued From page 31 psychiatric recommendation for one resident (#9) of thirty-nine residents reviewed. The facility's failure to notify the physician of significant behaviors for Resident #21 placed all residents on the 2nd Tennessee (2nd TN) unit in an environment which was detrimental to their health, safety, and welfare. The findings included: Resident #21 was admitted to the facility on August 19, 2011, with diagnoses including Mental Disorder, Anxiety, and Previous Head Injury - Traumatic. Medical record review of an assessment dated February 12, 2012, revealed the resident scored 4 out of 15 on the Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment, had exhibited physical behavioral symptoms directed toward others, and was independent with ambulation. Medical record review of the Mental/Behavioral Health Progress Notes dated January 3, 2012, revealed, "...replied that he was concerned about his ex-wife...went on to say that he has seen his wife w/ (with) other residents and this bothered him...went on to reiterate further delusional beliefs about his ex-wife's behaviors...tends to obsess about this..." Medical record review of the Nurse's Notes dated January 12, 2012, at 6:30 p.m., revealed, "...Resident also displaying some protectiveness i.e. (that is) female residents - resident raised his voice in loud tone this am (morning) when talking to male resident. This resident thought other male resident was (after) his wife...explained to	N 669	• **Resident # 21 was placed on fifteen minute observation by the Corporate Sr. Director of clinical services on 3/30/2012 at 10:30 am.** **Resident #21 was transferred to Medical Center for an Evaluation and placement to a behavior unit on 3/30/2012 at 4:00pm. The facility will not readmit this resident to the facility.** • **The nurses' note for resident # 32 dated 1/14/2012 states the resident "having questionable bleeding from rectal area. MD notified with new orders to send resident to ER for evaluation and treatment. RP was notified of residents' status and aware of resident going to the ER." Nurse's note dated 1/14/2012 at 6:00pm states the resident was admitted to BRMC with a diagnosis of Pneumonia. The hospital was not notified of the possibility of a sexual assault.** • **The Physician was notified of the alleged sexual abuse allegation for resident #32 by the facility on 4/10/2012 by the Chief Executive Office, Director of Nursing. Corporate Quality Assurance nurse and Corporate Director of Clinical services.**	

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N 669	Continued From page 32 this resident (reoriented) minimal success noted..." Interview with Certified Nurse Aide (CNA) #1 on March 30, 2012, at 1:52 p.m., in the conference room, confirmed resident #21 frequently wandered the halls of the unit, in other resident rooms, and liked to be with female residents in their rooms. Further interview confirmed the CNA had worked on two occasions in January 2012, when the resident was seen exiting a female resident's room. Further interview confirmed the first instance the CNA recalled was around the week of January 9, 2012, when the resident was seen exiting a room (empty resident room which had not been assigned to any residents) carrying linen. Interview confirmed the CNA entered the room and resident #32 was in bed with no clothes on, and a brief had been removed from the resident with blood present in the brief. Continued interview confirmed the CNA reported the incident to Licensed Practical Nurse (LPN) #11. Continued interview confirmed the CNA also observed the resident (resident #21) exiting resident #17's room sometime in January, and upon entering the room, found the resident fully clothed, one side of the brief undone. Interview with LPN #11 on March 31, 2012, at 7:15 a.m., and 9:00 a.m., on 2nd Tennessee, confirmed the LPN was working sometime in January when CNA #1 reported to LPN #11 resident #21 had exited a room (empty resident room which had not been assigned to any residents) carrying ladies clothing. Continued interview confirmed resident #32 was in the room with no clothes on, and a brief had been removed (unknown who removed) with blood in the brief and blood on the resident's rectal area. Continued interview confirmed LPN #11 was not	N 669	• **The social worker completed a PHQ9 assessment on 3/31/2012 to assess resident #32 for signs and symptoms of depression and to identify possible changes in signs and symptoms of mood distress since her last assessment. The assessment revealed that there was no change from the residents' baseline. ((The PHQ-9 is a 9 item patient health questionnaire. A validated interview that screens for symptoms of depression. It provides a standardized severity score and a rating for evidence of a depressive disorder. The total severity provides a standard of communication with clinicians and mental health specialist.)** • **Resident # 32 care plan was updated by social services, MDS Coordinator Quality Assurance Nurse and Sr. Director of clinical services on 03/31/2012 to reflect the need to notify the MD and social services of changes in mood and behaviors.** • **The charge nurses will utilize the Psychoactive Medication monthly flow record or the nurses notes to document resident changes in mood and or behaviors.** • **It is the responsibility of the charge nurses to notify the MD and social services of any mood and behavior changes.**	

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N 669	Continued From page 33 the nurse caring for resident #32 but cleaned the resident and reported it to the resident's nurse. Continued interview confirmed the resident was sent to the hospital the same day. Continued interview confirmed the LPN did not remember what day it was, but the resident was sent to the hospital and the occurrence was around 11:00 a.m., to 12:00 p.m. Continued interview confirmed the LPN had never known resident #32 to completely undress herself. Continued interview confirmed the LPN thought there was an opportunity for an inappropriate sexual situation to have occurred, but did not know if an incident report had been completed or the incident investigated. Continued interview confirmed for incidents of sexual inappropriate behavior, staff were to immediately notify the supervisor in person or by phone, and the LPNs were not responsible for completing incident reports and the LPN did not know if the physician was not notified. Medical record review of the nursing notes dated January 2012, for resident #32 revealed no documentation of an incident with resident #21 exiting the room. Review of the nursing notes dated January 14, 2012, at 10:50 a.m., revealed, "Res (resident) (resident #32) having questionable bleeding from rectal area. MD (physician) notified...Send res to ER (emergency room)..." Review of the nurses notes for January 14, 2012 revealed no documentation the MD was notified of possible sexual abuse to resident #32 by resident #21. Medical record review of the hospital records for resident #32 dated January 14, 2012, revealed, "...Chief complaint: Bright red blood in diaper...history of the dementia who is unable to provide a review of symptoms secondary to her	N 669	**2. How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken?** **• All residents have the potential to be affected by this alleged deficient practice.** **• The RN supervisor completed an audit on all blood sugar flow sheets to assess for compliance with M.D. notification related to hypo/hyperglycemic on 4/10/2012.** **• The DON, ADON and Social Services reviewed psychiatric services progress notes for visit from 3/30/2012 to 4/3/2012 to ensure psychiatric recommendations were completed timely. All recommendations were** place in the physician notification folder for the physician to review. **• MD and or NP make facility visits** four times a week to assess the **residents and to review consultant recommendations that have been placed in the physician folder.** **• The Director of Nursing; Assistant Director of Nursing; Staff** Development Coordinator and or the Quality Assurance Nurse will provide **re-education to all licensed nurses**	

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N 669	Continued From page 34 dementia...patient has had bright red blood noted in her diaper..." Interviews with the Senior Director of Clinical Services on March 30, 2012, at 12:20 p.m., in the conference room, and with the Director of Nursing (DON) on March 31, 2012, at 9:30 a.m., in the Assistant Director of Nursing (ADON's) office, confirmed the facility had no incident reports or investigations for the witnessed event January 14, 2012. Medical record review of the Psychiatric Note dated January 17, 2012, revealed, for resident #21"...staff report that resident continues to have a preoccupation with female residents. He has been found in a female resident's bed in the past. He is always pushing their with C's (wheelchairs) or holding hands with various other residents. Staff are concerned this could escalate into a problem and wonder if depo-provera might be a possibility...he denies the above behaviors..." Medical record review of the nurse's notes dated January 18, 2012, at 3:45 p.m., revealed, "...CNA came to this nurse and reported finding (resident #21) in (room number) with him exiting the doorway, female residents (resident #17) brief undone & (and) her positioning vest off her body. CNA directed male resident (resident #21) back up hallway & redressed female resident (resident #17)..." 4:30 p.m., "Nurse practitioner psych (psychiatric) ordered Depo Provera IM (intramuscular) once a month for sexual behaviors..." Medical record review of the nurse's notes dated January 19, 2012, at 6:15 p.m., revealed, "While walking down hallway on long hall 2nd TN (Tennessee) looking for (resident #21) noticed a	N 669	**regarding Physician notification of hyperglycemic/Hypoglycemic blood sugar results and the fact that Blood sugar notification parameters are established by each Physician. The training started on 4/10/ 2012 and will be completed by April 11th, 2012.** **• All staff who missed the in-service will be in-serviced by the staffing coordinator and or the corporate Quality assurance nurse prior to being allowed to work the floor.** **• The facility do not use agency staff.** **• The Director of Nursing; Assistant Director of Nursing; Staff Development Coordinator and or the** Quality Assurance Nurse will provide re-education to all licensed nurses **regarding timely notification of Psychiatric recommendations to the attending Physicians. All staff who missed the in-service will be in-serviced by the staffing coordinator and or the corporate Quality assurance nurse prior to being allowed to work the floor. The facilities do not use agency staff.**	

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N 669	Continued From page 35 white sock in doorjam of rm (room). Upon entering room, (resident #21) was in bed A of room...along with female resident (resident #36). Female resident (resident #36) was fully clothed, not seeming to be disturbed by incident. (Resident #21) immediately started to rise out of bed at bottom of bed. His trousers were off, underwear on. He was told to put his pants on & exit room and was sent to dayroom. When female resident (resident #36) was asked about situation she said 'I don't know what this looks like.' When asked if she was OK, harmed, or hurt she stated she was 'OK'. Seemed to be unaware of situation. Female resident was fully clothed in gown, brief on & intact. Covers off resident. Call placed to Director of Nursing..." Interviews with the Senior Director of Clinical Services on March 30, 2012, at 12:20 p.m., in the conference room and with the DON on March 31, 2012, at 9:30 a.m., in the ADON's office, confirmed the facility had no incident reports or investigations for the documented event January 19, 2012. Medical record review of the Mental/Behavioral Health Progress Notes for resident #21 dated January 19, 2012, revealed, "...alert and oriented to times 3...some confusion, less delusional beliefs...(Nursing staff requested this therapist visit w/ patient due to boundary issues: Pt (patient) entering other residents rooms at times, requiring some redirection)...asked Pt if he was aware of a problem involving a resident entering other residents' rooms causing some problems. Pt admitted that 'he had done this a couple of times by mistake and that he didn't mean to, adding a vague and superficial reason.' This Thx (therapist) provided Confrontive Therapy in stating that Pt was oriented to location to his	N 669	• **The Director of Nursing; Assistant Director of Nursing; Corporate Quality Assurance Nurse will provide re-education to all licensed nurses on implementing interim plans of care for new admissions, updating care plans with resident changes including behavior changes. The training was initiated on 4/10/2012 and will be completed by 4/11/2012.** • **All staff who missed the in-service will be in-serviced by the staffing coordinator and or the corporate Quality assurance nurse prior to being allowed to work the floor.** • **The facilities do not use agency staff.** • **The Unit Managers will audit the diabetic flow records daily to ensure Physician notification of hypoglycemic /hyperglycemic episodes is documented on the Blood sugar flow sheets. Audits began 4/10/2012**	

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N 669	Continued From page 36 room. Pt replied that he was. Pt replied that he would not enter other residents' rooms...reiterated boundary issues...clarifying loneliness in (is) no excuse. Adequate understanding - implementation remains questionable...often confused w/ some illogical thinking, poor judgment, some delusions..." Medical record review of the Psychiatric Note for resident #21 dated January 24, 2012, revealed, "...Staff report that resident continues his pursuit of female residents. They do not feel it is sexual but more of wanting to lay beside them probably because he misses his wife however there have been several close calls recently and staff have noticed that he will take a piece of paper or a sock and put it in the door while he is inside with a female resident..." Medical record review of the Mental/Behavioral Health Progress Notes dated January 31, 2012, revealed, "...alert and oriented to times 3...Thoughts processes relevant, confused, some delusional beliefs...Re-emphaiszed w/ Pt the importance of not entering anyone else's room. Pt agreed..." Medical record review of the Social Service Progress Notes for resident #21 revealed a note dated February 16, 2012, "Care Plan Review...Behavior concerns discussed as related to how resident wants to help others - i.e. (that is) transfers, etc. (etcetera) - will cont. (continue) to monitor..." Medical record review of the Social Service Progress Notes dated March 9, 2012, revealed, "Attempted referral to 5-E (psychiatric unit) - transported to hospital...aggressive behavior toward another individual..." Review of the Social	N 669	• **The weekend Nurse Manager will complete the daily audits on Saturday and Sunday.** • **Daily audits will be completed Sunday through Saturday's for four weeks then, Three times a week Sunday through Saturday for four weeks and then, weekly Sunday through Saturday for four weeks and then PRN.** • **The Unit managers will report audit findings to the interdisciplinary team (Director of Nursing(DON) , Assistant Director of Nursing(ADON), Chief Executive Officer(CEO), Social Services (SS), Admissions, Business Office Manager(BOM), Rehab Director (RD)) in the daily clinical** meeting. The DON/ADON will maintain all Audit tools in the survey readiness binder in the DON's office. • **The DON/ ADON and or Quality Assurance Nurse will audit 100% of the diabetic flow sheets weekly to ensure Physician notification of hyperglycemic episodes has been documented on the blood sugar flow sheets. Audits will be completed weekly for eight weeks and then PRN. Audits** began 4/10/2012.	

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N 669	Continued From page 37 Service Progress Notes revealed no other documentation of the resident's behaviors or any incidents with the resident exiting female resident rooms. Medical record review of the Mental/Behavioral Health Progress Notes dated March 15, 2012, revealed, "...alert and oriented to person and situation...mildly anxious...(Nursing staff requested this therapist visit w/ Patient due to some boundary issues and some behavioral problems)...Since Pt denied having any problems. Confrontive Therapy necessary relative to Pt's intruding into other residents' rooms. Pt stated that he gets a little confused at times. This Thx countered w/ Pt's ability to find his own room...Pt said he would remember to do this, he added that he is a nice man and does not want to cause problems..." Observation of the resident on March 29, 2012, at 10:37 a.m., on the 2nd TN hallway revealed the resident was pushing resident #17 down the hallway in a wheelchair, a CNA stated "are you going to be nice to her," allowing the resident (resident #21) to continue to push the resident (resident #17). Continued observation revealed LPN #4 intervened by taking resident #21 to the dayroom, sitting the resident in a chair and leaving the resident there with no staff present. Continued observation revealed the resident stated, "They aren't going to stop me. They are taking my rights away." Continued observation at 10:45 a.m., revealed resident #21 was again pushing resident #17 down the hall in a wheelchair when LPN #4 stated "(resident's name) will you let her go..." and resident #21 was redirected away from resident #17 who was taken to a room.	N 669	• **The DON and or ADON will review Psychiatric consultation notes after each visit to ensure recommendations for medication adjustments are called to the Physician in a timely manner.** • **The DON/ ADON and or Quality Assurance Nurse will audit 100% of the Psychiatric notes and the medical record to ensure the physician is notified of recommendations for medication changes from Psychiatric services.** • **Audits will be completed weekly for eight weeks and then biweekly for eight weeks and then PRN.** • **The DON/ADON will report audit findings to the interdisciplinary team (Administrator, Director of Nursing, Assistant Director of Nursing, Business Office Manager, Dietary Manager, Activities Director, Social Services Director, Therapy Manager) in the monthly Quality Assurance Committee meeting until system compliance is achieved.**	

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N 669	Continued From page 38 Interview with CNA #2 on March 30, 2012, at 9:05 a.m., at the 2nd TN nursing station, confirmed resident #21 had wandering behaviors, was very protective of female residents, liked to crawl into bed with female residents, had been "fondling women last few months...any woman - no one in particular...I think he knows more than he lets on. He knows what he is doing." Continued interview confirmed the resident had been found in bed, without clothes on, with one female resident. Continued interview confirmed "He is like this every day with females." Interviews with LPN #6 and LPN #7 on March 30, 2012, at 9:25 a.m., and 10:00 a.m., at the 2nd TN nursing station, confirmed the resident had a history of aggressive behaviors, which had been worsening since the resident's ex-spouse died in November, 2011, and he associated other female residents with his wife/ex-wife. Continued interview confirmed the resident was difficult to redirect at times and interventions did not work. Further interview confirmed the staff were to fill out incident reports when residents had altercations. Interviews with resident #38 and LPN #7 on March 30, 2012, at 9:40 a.m., at 2nd TN nursing station, revealed the LPN stated resident #38 was a reliable source of information and wanted to report an incident concerning resident #21. Interview with resident #38 revealed the resident was awakened early that morning with resident #21 standing over resident #38's bed, and resident #21 "scared" resident #38 causing resident #38 to slap resident #21's arm. Resident #38 stated resident #21 came to resident #38's room "more than I like" and resident #38 stated "I don't like it."	N 669	• **To ensure the facility staff understand how to properly manage residents with behaviors, how to report, investigate and implement interventions after a behavioral event. All staff will receive education on:** • **Managing residents with Dementia and Dementia related behaviors. Contracted Hospice provider is scheduled to provide the above training. The training began on 4/5/2012 and will be completed by April 11, 2012.** • **Implementation of interventions to prevent a behavior. Contracted Hospice provider is scheduled to provide the above training. The training began on 4/5/2012 and will be completed by April 11, 2012.** • **Implementation of interventions after a behavioral event has occurred. Contracted Hospice provider is scheduled to provide the above training. The training began on 4/5/2012 and will be completed by April 11, 2012. The training also included a review of the facility policy on Behavior assessment and monitoring by the Assistant Director of Nursing.**	

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N 669	Continued From page 39 Medical record review of the MDS for resident #38 dated February 19, 2012, revealed the resident scored 14 out of 15 on the BIMS, indicating no cognitive impairment. Medical record review of a Nurse's Notes for March 30, 2012, revealed the resident was started on every 15 minute observations at 10:30 a.m., and the following documentations, "...10:45A (a.m.)...Resident talking about women being with other men talking about I think my wife had 3-4 other men. Resident talking about resident female as if it was his late wife..." Observation of resident #21 and interview with the Assistant Director of Nursing (ADON) and Corporate Quality Assurance Nurse on March 30, 2012, from 3:51 p.m., until 4:02 p.m., on 2nd Tennessee, confirmed the resident had been on every 15 minute checks since 10:30 a.m., and was currently on one to one supervision, due to safety concerns for the other residents. Continue observation and interview confirmed resident #21 was transferred to the hospital at 4:02 p.m., for evaluation and treatment of behaviors. Interview with the Social Services Coordinator on March 30, 2012, at 4:20 p.m., in the Medical Records office, confirmed the Coordinator was aware the resident (resident #21) had an attraction to females which the Social Worker felt was due to the resident being a "caretaker" to the ex-spouse while in the same facility before the ex-spouse's death in November 2011. Continued interview with the Social Services Coordinator revealed, "...never thought the resident's behavior could be possibly abusive, "inappropriate, but not sexually motivated ...not abuse ...unclothed ...We worked on that one incident that I know of...was in bed with her I think or helped her to bed...I	N 669	• **The Corporate Sr. Director of clinical Services, corporate Quality Assurance Nurse and or Director of Nursing will educate all staff on the types of abuse, the policy and procedure for reporting and investigating abuse, Sexual behaviors and possible sexual abuse. The training began on 4/ 4/2012 and will end on 4/11/2012. This training also included mandatory reporting of Elder Abuse Act.** • **All staff who missed the in-services will be in-serviced by the staffing coordinator and or the corporate Quality assurance nurse prior to being allowed to work the floor. The facilities** do not use agency staff.	

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N 669	Continued From page 40 believe one had bottoms off...did not view his behaviors as sexually motivated ...if he had been making comments," but stated the resident never verbalized sexual comments or "talked dirty." Continued interview confirmed the resident had been placed on Depo-provera, which is used to treat sexual behaviors. Continued interview confirmed the Social Services Coordinator was not responsible for investigating incidents of possible abuse or physical altercations; incident reports for any alleged abuse were given to the Director of Nursing (DON) who completed all incident investigations. Telephone interview with the Psychiatric Nurse Practitioner (NP) on March 30, 2012, at 4:45 p.m., confirmed the NP had been treating the resident (resident #21) in conjunction with a clinical psychologist since the resident's ex-spouse died in November 2011. Continued interview confirmed they were unsure if the psychotherapy actually worked but the psychologist provided therapy for the resident and provided the NP with progress reports so the NP could manage medications. Continued interview confirmed the resident suffered a very accelerated decline in which the resident was more confused, sexually aggressive, was going into other resident rooms, and was aggressive towards males. Continued interview confirmed when the resident's ex-wife died, the sexual behaviors began with the resident wanting to be with female residents and kiss female residents. Further interview confirmed the NP was only familiar with the one incident in January when the resident was found in bed with a female resident with her fully clothed and resident #21 with his pants off and underwear on. Further interview confirmed the resident had exhibited other sexual behaviors such as when being found in the	N 669		

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N 669	Continued From page 41 female resident's room, a sock had been placed in the door jam and the NP was not sure if the resident was capable of intentionally blocking the door or if the dementia was causing the resident to act. Interview confirmed the NP believed medication interventions were needed to decrease the sexual behaviors, but depo-provera takes three months or more to show symptom improvement and "you do have to worry about other females." Telephone interview with the resident's physician on March 30, 2012, at 6:00 p.m., and 6:20 p.m., confirmed the resident had been "intermittently violent" but the physician was unaware of the resident's behaviors with other female residents and did not recall ever being notified the resident was seen coming out of female resident's rooms or in bed with female residents. Further interview confirmed no one had notified the physician of the resident exiting a room where resident #32 was unclothed and blood was present in a brief and rectal area. Telephone interview with LPN #5 on March 31, 2012, at 1:00 p.m., confirmed the LPN was the nurse who had called the physician and sent resident #32 to the hospital and the LPN had "no knowledge" of resident #21 being in the room prior to resident #32 being found nude, with blood in a brief. Interviews with the 2nd TN LPNs, the Social Services Director, the DON, and the Senior Director of Clinical Services during the survey from March 26, through March 31, 2012, confirmed the facility had not identified resident #21's as sexually motivated or possibly abusive and no investigations were completed and the facility's abuse protocol was not followed for	N 669		

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N 669	Continued From page 42 notification. Resident #9 was admitted to the facility on January 30, 2003, with diagnoses including Altered Mental Status, Acute Renal Failure, and Diabetes Mellitus. Medical record review of the Physician's Recapitulation Orders for March 2012, revealed "...Sliding Scale...greater than 351 (three-hundred and fifty one)...call MD (medical doctor)..." Medical record review of a Diabetic Monitoring Log for March 2012, revealed "...March 16, 2012 blood sugar 357 (three-hundred fifty-seven)...March 23, 2012, blood sugar 406 (four-hundred and six)..." Continued medical record review revealed no documentation the Physician was contacted. Medical record review of a Psychiatric Consultation dated February 6, 2012, revealed "...Recommend increasing Buspar (anxiety medication)...tid (three times a day) for anxiety symptoms..." Continued medical record review of a physician's order dated February 13, 2012, revealed "...start Buspar...tid..per...psych (psychiatric) np (nurse practitioner)..." Interview and medical record review with the Director of Nursing on March 29, 2012, at 2:15 p.m., in the bookkeeper office, confirmed the facility failed to notify the physician of the February 6, 2012, Psychiatric Consultation recommendation until February 13, 2012, (7 days later) and failed to notify the Physician of the elevated blood sugars.	N 669		

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N1207	Continued From page 43	N1207		
N1207	1200-8-6-.12(1)(g) Resident Rights (1) The nursing home shall establish and implement written policies and procedures setting forth the rights of residents for the protection and preservation of dignity, individuality and, to the extent medically feasible, independence. Residents and their families or other representatives shall be fully informed and documentation shall be maintained in the resident's file of the following rights: (g) To be free from mental and physical abuse. Should this right be violated, the facility must notify the department within five (5) working days. The Tennessee Department of Human Services, Adult Protective Services shall be notified immediately as required in T.C.A. §71-6-103; This Rule is not met as evidenced by: Based on medical record review, observation, review of facility documentation, interview, and review of facility policy, the facility failed identify and investigate possible abuse perpetrated by one resident (#21) for incidents with four residents (#17, #32, #36, and #38). The facility's failure to investigate incidents of possible abuse by resident #21 placed the female residents on the 2nd Tennessee (2nd TN) unit in an environment which was detrimental to their health, safety, and welfare. The findings included: Resident #21 was admitted to the facility on August 19, 2011, with diagnoses including Mental Disorder, Anxiety, and Previous Head Injury - Traumatic.	N1207	**1. What corrective actions(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?** • **The social worker completed a PHQ9 assessment on res. # 17 on 3/31/2012 to assess this resident for signs and symptoms of depression and to identify possible changes in signs and symptoms of mood distress since her last assessment. The assessment revealed that there was no change from the residents' baseline. (The PHQ-9 is a 9 item patient health questionnaire. A validated interview that screens for symptoms of depression. It provides a standardized severity score and a rating for evidence of a depressive disorder. The total severity provides a standard of communication with clinicians and mental health specialist.)**	Completion Date 4/11/12

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N1207	Continued From page 44 Medical record review of an assessment dated February 12, 2012, revealed the resident scored 4 out of 15 on the Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment, had exhibited physical behavioral symptoms directed toward others, and was independent with ambulation. Medical record review of the Mental/Behavioral Health Progress Notes dated January 3, 2012, revealed, "...replied that he was concerned about his ex-wife...went on to say that he has seen his wife w/ (with) other residents and this bothered him...went on to reiterate further delusional beliefs about his ex-wife's behaviors...tends to obsess about this..." Medical record review of the Nurse's Notes revealed dated January 12, 2012, at 6:30 p.m., revealed, "...Resident also displaying some protectiveness i.e. (that is) female residents - resident raised his voice in loud tone this am (morning) when talking to male resident. This resident thought other male resident was (after) his wife...explained to this resident (reoriented) minimal success noted..." Interview with Certified Nurse Aide (CNA) #1 on March 30, 2012, at 1:52 p.m., in the conference room, confirmed resident #21 frequently wandered the halls of the unit, in other resident rooms, and liked to be with female residents in their rooms. Further interview confirmed the CNA had worked on two occasions in January 2012, when the resident was seen exiting a female resident's room. Further interview confirmed the first instance the CNA recalled was around the week of January 9, 2012, when the resident was seen exiting a room (empty resident room which	N1207	• **Skin assessments dated 3/18/2012, 3/22/2012 and 3/26/2012 was completed by a charge nurse on resident # 17. No new skin issues were identified.** • **The care plan for res. # 17 was updated by social services, MDS Coordinator and Quality Assurance Nurse and Sr. Director of clinical services on 03/31/2012 to reflect the need to notify the MD and social services of changes in mood and behaviors. The Corporate Quality Assurance Nurse and the Sr. Director of clinical services immediately notified the charge nurses on duty of the changes made to the care plan.** • **The Director of Nursing updated resident care guides to ensure the nursing assistants were aware of the care plan changes on 4/11/2012.** • **The charge nurses will utilize the Psychoactive Medication monthly flow record and or the nurses notes to document resident changes in mood and or behaviors. It is the responsibility of the charge nurses to notify the MD and social services of any mood and behavior changes.**	

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N1207	Continued From page 45 had not been assigned to any residents) carrying linen. Interview confirmed the CNA entered the room and resident #32 was in bed with no clothes on, and a brief had been removed from the resident with blood present in the brief. Continued interview confirmed the CNA reported the incident to Licensed Practical Nurse (LPN) #11. Continued interview confirmed the CNA also observed the resident (resident #21) exiting resident #17's room sometime in January, and upon entering the room, found the resident fully clothed, with one side of the brief undone, and the resident with pants on. Interview with LPN #11 on March 31, 2012, at 7:15 a.m., and 9:00 a.m., on 2nd Tennessee, confirmed the LPN was working sometime in January when CNA #1 reported to LPN #11 resident #21 had exited a room (empty resident room which had not been assigned to any residents) carrying ladies clothing. Continued interview confirmed resident #32 was in the room with no clothes on, and a brief had been removed (unknown who removed) with blood in the brief and blood on the resident's rectal area. Continued interview confirmed LPN #11 was not the nurse caring for resident #32 but cleaned the resident and reported it to the resident's nurse. Continued interview confirmed the resident was sent to the hospital the same day. Continued interview confirmed the LPN did not remember what day it was, but the resident was sent to the hospital and the occurrence was around 11:00 a.m., to 12:00 p.m. Continued interview confirmed the LPN had never known resident #32 to completely undress herself. Continued interview confirmed the LPN thought there was an opportunity for an inappropriate sexual situation to have occurred, but did not know if an incident report had been completed or the	N1207	• **Resident # 21 was placed on fifteen minute observation on 3/30/2012 at 10:30 am. By the Corporate Sr. Director of Clinical Services.** • **Resident #21 was transferred to Medical Center for an Evaluation and placement to a behavior unit on 3/30/2012 at 4:00pm. This resident will not be readmitted to the facility.** • **The nurses' note for resident # 32 dated 1/14/2012 states the resident "having questionable bleeding from rectal area. MD notified with new orders to send resident to ER for evaluation and treatment. RP was notified of residents' status and aware of resident going to the ER." Nurse's note dated 1/14/2012 at 6:00pm states the resident was admitted to BRMC** with a diagnosis of Pneumonia. The hospital was not notified of the possible **sexual assault.** • **The social worker completed a PHQ9 assessment for resident # 32 on 3/31/2012 to assess this resident for signs and symptoms of depression and to identify possible changes in signs and symptoms of mood distress since her last assessment. The assessment revealed that there was no change from the residents' baseline.** **(The PHQ-9 is a 9 item patient health questionnaire. A validated interview that screens for symptoms of** depression. It provides a standardized	

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N1207	Continued From page 46 incident investigated. Continued interview confirmed for incidents of sexual inappropriate behavior, staff were to immediately notify the supervisor in person or by phone, and the LPNs were not responsible for completing incident reports. Telephone interview with LPN #5 on March 31, 2012, at 1:00 p.m., confirmed the LPN was the nurse who had called the physician and sent resident #32 to the hospital and the LPN had "no knowledge" of the resident #21 was being in the room prior to resident #32 being found nude, with blood in a brief. Medical record review of the nursing notes for January 2012, for resident #32 revealed no documentation of an incident with resident #21 exiting the room. Review of the nursing notes for January 14, 2012, at 10:50 a.m., revealed, "Res (resident) (resident #32)having questionable bleeding from rectal area. MD (physician) notified...Send res to ER (emergency room)..." Medical record review of the hospital records for resident #32 dated January 14, 2012, revealed, "...Chief complaint: Bright red blood in diaper...history of the dementia who is unable to provide a review of symptoms secondary to her dementia...patient has had bright red blood noted in her diaper..." Interviews with the Senior Director of Clinical Services on March 30, 2012, at 12:20 p.m., in the conference room and with the Director of Nursing (DON) on March 31, 2012, at 9:30 a.m., in the Assistant Director of Nursing's (ADON's) office, confirmed the facility had no incident reports or investigations for the witnessed event January 14, 2012.	N1207	**severity score and a rating for evidence of a depressive disorder. The total severity provides a standard of communication with clinicians and mental health specialist.)** • **Resident # 32 care plan was updated by social services, MDS Coordinator Quality Assurance Nurse and Sr. Director of clinical services on 03/31/2012 to reflect the need to notify the MD and social services of changes in mood and behaviors. The Corporate Quality Assurance Nurse and the Sr. Director of clinical services immediately notified the charge nurses on duty of the changes made to the care plan.** • **The Director of Nursing updated resident care guides to ensure the** nursing assistants were aware of the care plan changes on 4/11/2012.	Completion Date 4/11/12

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N1207	Continued From page 47 Medical record review of the Psychiatric Note for resident #21 dated January 17, 2012, revealed, "...staff report that resident continues to have a preoccupation with female residents. He has been found in a female resident's bed in the past. He is always pushing their with C's (wheelchairs) or holding hands with various other residents. Staff are concerned this could escalate into a problem and wonder if depo-provera might be a possibility...he denies the above behaviors..." Medical record review of the nurse's notes dated January 18, 2012, at 3:45 p.m., revealed, "...CNA came to this nurse and reported finding (resident #21) in (room number) with him exiting the doorway, female residents (resident #17) brief undone & (and) her positioning vest off her body. CNA directed male resident (resident #21) back up hallway & redressed female resident (resident #17)..." 4:30 p.m., "Nurse practitioner psych (psychiatric) ordered Depo Provera IM (intramuscular) once a month for sexual behaviors..." Interviews with the Senior Director of Clinical Services on March 30, 2012, at 12:20 p.m., in the conference room and with the DON on March 31, 2012, at 9:30 a.m., in the ADON's office, confirmed the facility had no incident reports or investigations for the documented event January 18, 2012. Medical record review of the nurse's notes dated January 19, 2012, at 6:15 p.m., revealed, "While walking down hallway on long hall 2nd TN (Tennessee) looking for (resident #21) noticed a white sock in doorjam of rm (room). Upon entering room, (resident #21) was in bed A of room...along with female resident (resident #36).	N1207	**• The social worker completed a PHQ9 assessment on resident # 36 on 3/31/2012 to assess this resident for signs and symptom of depression and to identify possible changes in signs and symptoms of mood distress since her last assessment. During the assessment this resident stated that this is not a good time for her, she is having problems with her daughter and at times she has thoughts that she would be better off dead. The resident stated no when the social worker asked her if she had a plan to harm herself. The social worker notified the nurse. The nurse obtained an order for a Psychiatric evaluation.** **• (The PHQ-9 is a 9 item patient health questionnaire. A validated interview that screens for symptoms of depression. It provides a standardized** severity score and a rating for evidence of a depressive disorder. The total **severity provides a standard of communication with clinicians and mental health specialist.)** **• The nursing staff observed the resident # 36 through out the night and**	Completion Date 4/11/12

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N1207	Continued From page 48 Female resident was fully clothed, not seeming to be disturbed by incident. (Resident #21) immediately started to rise out of bed at bottom of bed. His trousers were off, underwear on. He was told to put his pants on & exit room and was sent to dayroom. When female resident (resident #36) was asked about situation she said 'I don't know what this looks like.' When asked if she was OK, harmed, or hurt she stated she was 'OK'. Seemed to be unaware of situation. Female resident was fully clothed in gown, brief on & intact. Covers off resident. Call placed to Director of Nursing..." Interviews with the Senior Director of Clinical Services on March 30, 2012, at 12:20 p.m., in the conference room and with the DON on March 31, 2012, at 9:30 a.m., in the ADON's office, confirmed the facility had no incident reports or investigations for the documented event January 19, 2012. Medical record review of the Mental/Behavioral Health Progress Notes for resident #21 dated January 19, 2012, revealed, "...alert and oriented to times 3...some confusion, less delusional beliefs...(Nursing staff requested this therapist visit w/ patient due to boundary issues: Pt (patient) entering other residents rooms at times, requiring some redirection)...asked Pt if he was aware of a problem involving a resident entering other residents' rooms causing some problems. Pt admitted that 'he had done this a couple of times by mistake and that he didn't mean to, adding a vague and superficial reason.' This Thx (therapist) provided Confrontive Therapy in stating that Pt was oriented to location to his room. Pt replied that he was. Pt replied that he would not enter other residents' rooms...reiterated boundary issues...clarifying loneliness in (is) no	N1207	**completing thirty minutes observations until the resident was evaluated by psychiatric services.** • **A Psychiatric note dated 4/3/2012 reveals that this resident # 36 adamantly denies any thoughts, plans or intent of self harm stating "I could never do that, I have just been sadder lately".** • **The M.D was notified and agreed to the recommendations for Medication changes and the discontinuation of the frequent checks by the unit manager on 2nd Tennessee.** • **A skin assessment was completed on resident # 36 on 3/18/2012, 3/30/2012 which revealed no bruising or redness. The skin assessment was completed by the charge nurse.** • **Resident # 36 care plan was updated with refer to psych services, monitor every 15 to 30 minutes until seen by Psych services. Social Worker, MDS Coordinator, the Quality Assurance Nurse and Sr. Director of clinical services updated the care plan on 03/31/2012. The Corporate Sr. Director of Clinical Services and the Corporate Quality Assurance nurse immediately notified the nursing staff of the changes in the care plan.**	completion Date 4/11/12

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N1207	Continued From page 49 excuse. Adequate understanding - implementation remains questionable...often confused w/ some illogical thinking, poor judgment, some delusions..." Medical record review of the Psychiatric Note for resident #21 dated January 24, 2012, revealed, "...Staff report that resident continues his pursuit of female residents. They do not feel it is sexual but more of wanting to lay beside them probably because he misses his wife however there have been several close calls recently and staff have noticed that he will take a piece of paper or a sock and put it in the door while he is inside with a female resident..." Medical record review of the Mental/Behavioral Health Progress Notes for resident #21 dated January 31, 2012, revealed, "...alert and oriented to times 3...Thoughts processes relevant, confused, some delusional beliefs...Re-emphaiszed w/ Pt the importance of not entering anyone else's room. Pt agreed..." Medical record review of the Social Service Progress Notes for resident #21 revealed a note dated February 16, 2012, "Care Plan Review...Behavior concerns discussed as related to how resident wants to help others - i.e. (that is) transfers, etc. (etcetera) - will cont. (continue) to monitor..." Medical record review of the Social Service Progress Notes for resident #21 dated March 9, 2012, revealed, "Attempted referral to 5-E (psychiatric unit) - transported to hospital...aggressive behavior toward another individual..." Review of the Social Service Progress Notes revealed no other documentation of the resident's behaviors or any incidents with	N1207	• **The M.D was notified and agreed with recommendations from psychiatric services for Medication changes and the discontinuation of the frequent checks on 4/3/2012.** • **Care plan was updated with D/C frequent checks on 4/3/2012 by the unit manager. The Director of nursing updated the resident care guides to ensure the nursing assistants were aware of the changes to the plan of care.** • **The social worker completed a PHQ9 assessment on resident # 38 on 4/9/2012 to assess this resident for signs and symptoms of depression and to identify possible changes in signs and symptoms of mood distress since her last assessment. The assessment revealed that there was no change from the residents' baseline. This assessment was documented in the social services note.** • **(The PHQ-9 is a 9 item patient health questionnaire. A validated interview that screens for symptoms of depression. It provides a standardized severity score and a rating for evidence of a depressive disorder. The total severity provides a standard of communication with clinicians and mental health specialist.)** completion Date 4/12/11	

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N1207	Continued From page 50 the resident exiting female resident rooms. Medical record review of the Mental/Behavioral Health Progress Notes for resident #21 dated March 15, 2012, revealed, "...alert and oriented to person and situation...mildly anxious...(Nursing staff requested this therapist visit w/ Patient due to some boundary issues and some behavioral problems)...Since Pt denied having any problems. Confrontive Therapy necessary relative to Pt's intruding into other residents' rooms. Pt stated that he gets a little confused at times. This Thx countered w/ Pt's ability to find his own room...Pt said he would remember to do this, he added that he is a nice man and does not want to cause problems..." Observation of the resident on March 29, 2012, at 10:37 a.m., on the 2nd TN hallway revealed the resident was pushing resident #17 down the hallway in a wheelchair, a CNA stated "are you going to be nice to her," allowing the resident (resident #21) to continue to push the resident (resident #17). Continued observation revealed LPN #4 intervened by taking resident #21 to the dayroom, sitting the resident in a chair and leaving the resident there with no staff present. Continued observation revealed the resident stated, "They aren't going to stop me. They are taking my rights away." Continued observation at 10:45 a.m., revealed resident #21 was again pushing resident #17 down the hall in a wheelchair when LPN #4 stated "(resident's name) will you let her go..." and resident #21 was redirected away from resident #17 who was taken to a room. Interview with CNA #2 on March 30, 2012, at 9:05 a.m., at the 2nd TN nursing station, confirmed resident #21 had wandering behaviors, was very	N1207	• **A skin assessment was completed on res. # 38 on. 3/30/2012. The skin assessment revealed that the resident had bruising from blood draws and around her Dialysis Shunt. The skin assessment was completed by the charge nurse.** • **Resident # 38 care plan was updated by social services, MDS Coordinator Quality Assurance Nurse and Sr. Director of clinical services on 03/31/2012 to reflect the need to notify the MD and social services of changes in mood and behaviors. The Corporate Quality Assurance Nurse and the Sr. Director of clinical services immediately notified the charge nurses on duty of the changes made to the care plan.** • **The Director of Nursing updated** resident care guides to ensure the nursing assistants were aware of the care plan changes on 4/11/2012. • The charge nurses will utilize the **Psychoactive Medication monthly flow record to document resident changes in mood and or behaviors. It is the responsibility of the charge nurses to notify the MD and social services of any mood and behavior changes. The charge nurse will immediately notify the MD and social services of residents exhibiting abusive behaviors.**	completion Date 4/11/12

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N1207	Continued From page 51 protective of female residents, liked to crawl into bed with female residents, had been "fondling women last few months...any woman - no one in particular...I think he knows more than he lets on. He knows what he is doing." Continued interview confirmed the resident had been found in bed, without clothes on, with one female resident. Continued interview confirmed "He is like this every day with females." Interviews with LPN #6 and LPN #7 on March 30, 2012, at 9:25 a.m., and 10:00 a.m., at the 2nd TN nursing station, confirmed the resident had a history of aggressive behaviors, which had been worsening since the resident's ex-spouse died in November, 2011, and he associated other female residents with his wife/ex-wife. Continued interview confirmed the resident was difficult to redirect at times and interventions did not work. Further interview confirmed the staff were to fill out incident reports when residents had altercations. Interviews with resident #38 and LPN #7 on March 30, 2012, at 9:40 a.m., at 2nd TN nursing station, revealed the LPN stated resident #38 was a reliable source of information and wanted to report an incident concerning resident #21. Interview with resident #38 revealed the resident was awakened early that morning with resident #21 standing over resident #38's bed, and resident #21 "scared" resident #38 causing resident #38 to slap resident #21's arm. Resident #38 stated resident #21 came to resident #38's room "more than I like" and resident #38 stated "I don't like it." Medical record review of an assessment for resident #38 dated February 19, 2012, revealed the resident scored 14 out of 15 on the BIMS,	N1207	**2. How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken?** **All residents on 2nd Tennessee may be affected by the same alleged deficient practice.** **Skin assessment was completed on 100% of the resident in 2nd Tennessee by the charge nurse to assess for unknown bruises and or abrasions.** **• The PHQ9 assessment tool was used to assess residents for signs and symptoms of depression and to identify possible changes in signs and symptoms of mood distress since his/her last assessment.** **• (The PHQ-9 is a 9 item patient health questionnaire. A validated interview that screens for symptoms of depression. It provides a standardized severity score and a rating for evidence of a depressive disorder. The total severity provides a standard of Communication with clinicians and mental health specialist.)** Completion Date 4/11/12	

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N1207	Continued From page 52 indicating no cognitive impairment. Medical record review of the Nurse's Notes for March 30, 2012, revealed the resident was on every 15 minute observations and the following documentations, "...10:45A (a.m.)...Resident talking about women being with other men talking about I think my wife had 3-4 other men. Resident talking about resident female as if it was his late wife..." Observation of resident #21 and interview with the ADON and Corporate Quality Assurance Nurse on March 30, 2012, from 3:51 p.m., until 4:02 p.m., on 2nd Tennessee, confirmed the resident had been on every 15 minute checks since 10:30 a.m., and was currently on one to one supervision, due to safety concerns for the other residents. Continue observation and interview confirmed resident #21 was transferred to the hospital at 4:02 p.m., for evaluation and treatment of behaviors. Interview with the Social Services Coordinator on March 30, 2012, at 4:20 p.m., in the Medical Records office, confirmed the Coordinator was aware the resident (resident #21) had an attraction to females which the Social Worker felt was due to the resident being a "caretaker" to the ex-spouse while in the same facility before the ex-spouse's death in November, 2011. Continued interview with the Social Services Coordinator revealed, "...never thought the resident's behavior could be possibly abusive, "inappropriate, but not sexually motivated...not abuse...unclothed...We worked on that one incident that I know of...was in bed with her I think or helped her to bed...I believe one had bottoms off...did not view his behaviors as sexually motivated...if he had been making comments,"	N1207	**To prevent a reoccurrence of this alleged deficient practice the following changes has been implemented.** **• On 3/30/2012 Staffing was increased by 43% (4- staff members) on the 7A-7P shift and increased by 25% (2 staff members) on the 7P -7A shift. Staffing will be increased to six nursing assistants on the 7A-7P shift and five nursing assistants on the 7P – 7A shift as soon as the facility can maintain the new staffing levels. This will be permanent staffing level.** **• To increase and retain the increased number of staff on 2nd Tennessee the facility has Placed a newspaper ad locally, on Craig's list and, on Monster.com for C.N.A'.s, LPN'.s and RN's.** **• Offering a $500.00 new hire sign on Bonus for LPN's and C.N.A.'s.** **• Offering a $250.00 referral Bonus to current employee that refers other nursing staff that are hired and stay past ninety days.** **• A perfect attendance Bonus of an additional twenty-five cent per hour worked per pay period has been implemented for nursing assistants.** **• To ensure the facility staff understand how to properly manage residents with behaviors, how to report, investigate and implement interventions after a behavioral event. All staff will receive education on:** Completion Date 4/11/12	

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N1207	Continued From page 53 but stated the resident never verbalized sexual comments or "talked dirty." Continued interview confirmed the resident had been placed on Depo-provera, which is used to treat sexual behaviors. Continued interview confirmed the Social Services Coordinator was not responsible for investigating incidents of possible abuse or physical altercations; incident reports for any alleged abuse were given to the DON who completed all incident investigations. Telephone interview with the Psychiatric Nurse Practitioner (NP) on March 30, 2012, at 4:45 p.m., confirmed the NP had been treating the resident (resident #21) in conjunction with a clinical psychologist since the resident's ex-spouse died in November 2011. Continued interview confirmed they were unsure if the psychotherapy actually worked but the psychologist provided therapy for the resident and provided the NP with progress reports so the NP could manage medications. Continued interview confirmed the resident suffered a very accelerated decline in which the resident was more confused, sexually aggressive, was going into other resident rooms, and was aggressive towards males. Continued interview confirmed when the resident's ex-wife died, the sexual behaviors began with the resident wanting to be with female residents and kiss female residents. Further interview confirmed the NP was only familiar with the one incident in January when the resident was found in bed with a female resident with her fully clothed and resident #21 with his pants off and underwear on. Further interview confirmed the resident had exhibited other sexual behaviors such as when being found in the female resident's room, a sock had been placed in the door jam and the NP was not sure if the resident was capable of intentionally blocking the	N1207	• **Managing residents with Dementia and Dementia related behaviors. Contracted Hospice provider is scheduled to provide the above training. The training began on 4/5/2012 and will be completed by April 11, 2012.** • **Implementation of interventions to prevent a behavior. Contracted Hospice provider is scheduled to provide the above training. The training began on 4/5/2012 and will be completed by April 11, 2012.** • **Implementation of interventions after a behavioral event has occurred. Contracted Hospice provider is scheduled to provide the above training. The training began on 4/5/2012 and will be completed by April 11, 2012.** • **The training also included a review of the facility policy on Behavior assessment and monitoring by the Assistant Director of Nursing.** • **The Corporate Sr. Director of clinical Services, corporate Quality Assurance Nurse and or Director of Nursing will educate all staff on the types of abuse, the policy and procedure for reporting and investigating abuse, Sexual behaviors and possible**	Completion Date 4/11/12

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N1207	Continued From page 54 door or if the dementia was causing the resident to act. Interview confirmed the NP believed medication interventions were needed to decrease the sexual behaviors, but depo-provera takes three months or more to show symptom improvement and "you do have to worry about other females." Telephone interview with resident #21's physician on March 30, 2012, at 6:20 p.m., confirmed the resident had been "intermittently violent" and the physician had on two other occasions sent the resident to the emergency room for evaluation and admission to a psychiatric unit, but the resident was returned to the facility without being admitted. Further interview confirmed the physician had been trying to have the resident admitted to a psychiatric unit due to the need for more intense monitoring and management of behaviors. Further interview confirmed the physician was unaware of the resident's behaviors with other female residents and did not recall ever being notified the resident was seen coming out of female resident's rooms. Further interview confirmed staff needed "to keep an eye on him." Resident #17 was admitted to the facility on October 28, 2011, with diagnoses including Dementia, Abnormality of Gait, Muscle Weakness, and Malnutrition. Medical record review of an assessment dated January 22, 2012, revealed the resident was unable to complete the BIMS, had short and long term memory problems, severely impaired cognition, and was totally dependent on all staff for activities of daily living. Medical record review of the nurse's notes and	N1207	**sexual abuse. The training began on 4/ 4/2012 and will end on 4/11/2012. This training also included mandatory reporting of Elder Abuse Act** • **All staff who missed the in-service will be in-serviced by the staffing coordinator and or the corporate Quality assurance nurse prior to being allowed to work the floor. The facilities do not use agency staff.** **.The Director of Nursing, Assistant Director of Nursing and or the Chief Executive Director (Administrator) will investigate all allegations of abuse immediately and will report the** allegations and the findings of the investigation to the appropriate state agencies. • **The interdisciplinary team will review all allegations of abuse in the daily clinical meeting and in the monthly Quality Assurance meeting.** Completion Date 4/11/12	

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N1207	Continued From page 55 Social Service Progress Notes revealed no documentation of the incident on January 18, 2012, when resident #21 was observed exiting the resident's room with the resident's vest undone and one edge of the resident's brief undone. Resident #36 was admitted to the facility on November 14, 2011, with diagnoses including Senile Delirium and Alzheimer's. Medical record review of an assessment dated January 30, 2012, revealed the resident scored 3 out of 15 on the BIMS, indicating severe cognitive impairment, and was totally dependent on all staff for activities of daily living. Medical record review of the nurse's notes and the Social Service Progress Notes revealed no documentation of the incident on January 19, 2012, when resident #21 was found in resident #36's room, lying in the resident's bed with pants down, and underwear on. Review of all incidents and investigations provided by the facility for resident #21 revealed the only incidents the facility had investigated were physical altercations with male residents dated February 4, February 5, February 7, March 1, March 9, and March 27, 2012. Review of the facility's policy Abuse/Neglect/Mistreatment: Guidelines for Prevention /Identification/Investigation, revealed, "...Sexual Abuse - sexual harassment, coercion or assault...The facility will be proactive in identifying occurrences, patterns and/or trends that may constitute possible/potential abuse or neglect...The staff will be educated on the reporting procedure...and to report any concerns	N1207		

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N1207	Continued From page 56 they may have with respect to abuse and neglect...shall track and trend all incidents/accidents and monitor for any occurrences that may constitute potential abuse/neglect...The facility will...thoroughly investigate...trends noted during tracking of incidents/accidents, to determine if abuse or neglect was involved...The results of the investigation will be reported to the CEO (Chief Executive Officer)...Any complaint of, observation of, or suspicion of resident abuse, mistreatment or neglect is to be thoroughly investigated, documented and reported...All employees are required to immediately notify the CEO or DNS (Director of Nursing Services), or supervisor on duty, of any...observation of, or suspicion of resident abuse, neglect or mistreatment..." Interview with the DON on March 29, 2012, at 3:25 p.m., in the DON's office, and review of the facility's abuse policy and investigations confirmed all allegations and instances of suspected abuse were to be reported, investigated, and witness statements obtained. Interviews with the Senior Director of Clinical Services on March 30, 2012, at 12:20 p.m., in the conference room and with the DON on March 31, 2012, at 9:30 a.m., in the ADON's office, confirmed the facility had no incident reports, investigations or interventions related to the witnessed incidents regarding residents #21, #17, #32, and #36 and no incidents had been investigated as possible abuse. Further interviews confirmed they were unaware of the incidents. Interviews with the 2nd TN LPNs, the Social Services Director, the DON, and the Senior Director of Clinical Services during survey from	N1207		

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N1207	Continued From page 57 March 26, through March 31, 2012, confirmed the facility had not identified resident #21's behaviors as sexually motivated or possibly abusive and no investigations were completed and the facility's abuse protocol was not followed.	N1207		